County of Los Angeles - Department of Mental Health
Countywide Housing, Employment and Education Resource Development
Federal Housing Subsidies Unit

HACLA SHELTER PLUS CARE APPLICATION COVERSHEET & CHECKLIST - (rev. 11/04/16)

The following forms are **required for every applicant** under the Section 8 Homeless Program. In order for the Housing Authority to expedite the process of reviewing and approving your referrals, **please complete all forms thoroughly**. Place a check mark next to those documents included in this application packet and arrange forms in the following order:

_____ **1.** HACLA Shelter Plus Care Application Coversheet and Checklist
_____ **2.** Housing Intake and Needs Assessment, ***3 pages***
_____ **3.** HMIS Intake and Enrollment Form, ***13 pages*** *to be completed for* ***each adult and minor*** *in the household*
_____ **4.** Authorization for Request or Use/Disclosure of Protected Health Information ***(MH 677 LA/OC HMIS), 2 pages***
_____ **5.** Authorization for Request or Use/Disclosure of Protected Health Information ***(MH 677 HACLA), 2 pages***
_____ **6.** LACDMH Notice of Privacy Practices: Acknowledgement of Receipt ***(form MH 601E, 9/13)***
_____ **7.** Service Provider Responsibility Form, ***2 pages***
_____ **8.** Shelter Plus Care Client Agreement
_____ **9**. Affordable Care Act Certification Form
_____ **10**. McKinney Vento Act Notice - Acknowledgement of Receipt
_____ **11.** Agency Referral Letter – including a 3-year timeline of housing / homelessness history
(Include explanation of address on ID if different from current address & why client can't return there.)

CORE APPLICATION

_____ **12.** Special Programs Application for Rental Assistance, ***11 pages*** This form is not on the web, contact FHSU
_____ **13.** Declaration of Citizenship/Eligible Immigration Status ***(forms NC-100A & NC-101), 2 pages***
_____ **14.** Authorization to Release of Information ***(form HAPP-86A)*** *signed by* ***all*** *adults*
_____ **15.** Authorization for Release of Information, ***2 pages*** *signed by* ***all*** *adults*
_____ **16.** Authorization for the Release of Information/Privacy Act Notice ***(form HUD-9886), 2 pages***
_____ **17.** Supplement to Application For Federally Assisted Housing ***(form HUD-92006)***
_____ **18.** Debts Owed to Public Housing Agencies and Terminations ***(form HUD-52675), 2 pages***, *signed by* ***all*** *adults*
_____ **19.** CalWORKs Homelessness Certification ***(form ANC-CW-1, 4/12),*** *signed by* ***all*** *adults*
_____ **20.** Certified Statement – Yes/No Questionnaire (***form ANC-19, 7/12***), *for* ***all*** *adults 18 years of age and older*
_____ **21.** Things You Should Know ***(form HUD-1140-OIG), 2 pages***, *signed by* ***all*** *adults*
_____ **22.** Reasonable Accommodation Questionnaire ***(form S504-02, 1/13)*** *** LEGAL SIZED PAPER ***
_____ **23.** Verification of DPSS Assistance ***(form RE-29, 4/05)*** *** LEGAL SIZED PAPER ***
_____ **24.** Authorization for Release of Confidential DPSS Information ***(form RE-DPSS)***

HACLA SHELTER PLUS CARE INSERT

_____ **25.** HACLA Shelter Plus Care Application Coversheet and Checklist *** LEGAL SIZED PAPER ***
_____ **26.** Referral Transmittal Form
_____ **27.** CES Referral Form, *completed by the CES Regional Leads for applicants prioritized though CES* ***only***
_____ **28.** Shelter Plus Care Applicant Questionnaire ***(form Special Programs 4, 10/13),*** *completed by* ***each*** *adult*
_____ **29.** Shelter Plus Care Clearance ***(form Special Programs Clearance, 10/13)***
_____ **30.** Certification of Homelessness / Residence ***(form Special Programs.HM-1, 10/13)*** *** LEGAL SIZED PAPER ***
_____ **31.** Certification of Chronic Homelessness ***(form Special Programs-2, 10/13), 2 pages***
_____ **32.** Disability Certification <u>with agency stamp at bottom</u> ***(form Special Programs.Dis-3, 10/13)*** *** LEGAL SIZED PAPER ***
_____ **33.** Shelter Plus Care Family Obligations or Statement of Family ***(HAPP-149, 2/2010), 2 pages,*** *signed by* ***all*** *adults*
*** LEGAL SIZED PAPER ***
_____ **34.** Certification of No Conflict of Interest ***(SPC – CoC 1, 2/2016)*** *** LEGAL SIZED PAPER ***
_____ **35.** Statement of Family Responsibility (Supportive Services) ***(form Special Programs – supp, 10/13)***
_____ **36.** Certified Statement ***(form RE-46, 06/11)***
_____ **37.** Limited English Proficiency Notice – Section 8 ***(form LEP-02, 7/11)***
_____ **38.** Verification of Income (refer to item #24 on this checklist to provide different types of verification that apply)
_____ **39.** Identification Documents
____ Current California Photo ID or Current California Driver's License, *for* ***all*** *adults in the household*
____ Signed Social Security Cards, *for* ***all*** *household members*
____ Birth Certificates, *for* ***all*** *minors in the household*
____ Permanent Residence Card – both sides, (if applicable)

Client Name: _____ **SSN:** _____

Submitted by: _____ **Date:** _____

Agency: DMH / _____ **Agency Phone #:** _____

Service Area: _____ **Supervisorial District:** _____

County of Los Angeles - Department of Mental Health
Countywide Housing, Employment, and Education Resource Development

HOUSING INTAKE AND NEEDS ASSESSMENT

Date of Assessment

Housing History:

What is client's current living situation?

☐ Motel ☐ Board and Care ☐ Streets, car, parks ☐ Transitional residential program
☐ Sober living home ☐ Friends/family ☐ Homeless shelter
☐ Apartment/SRO ☐ Other _____

Specify name or closest street: _____

Length of time in current situation? ☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ 12 months or longer

How many people does client live with? _____

Who does client live with? _____

Does client share a room? ☐ Yes ☐ No If yes, with whom? _____

Does client pay rent? ☐ Yes ☐ No If yes, how much? _____

Does client have a key? ☐ Yes ☐ No Does client's unit have running water/electricity? ☐ Yes ☐ No

Does client have access to bathroom and cooking facilities? ☐ Yes ☐ No

What kind of agreement does client have to live there? (lease/informal agreement)

_____

Financial Situation:

What is client's total monthly income? _____

Source of Income: ☐ SSI ☐ GR ☐ VA ☐ SSDI ☐ SDI ☐ CALWORKs/TANF
☐ Food Stamps ☐ Child Support ☐ Employment ☐ Other (such as family support)
☐ Unemployment Insurance ☐ None

Is income expected in the future? ☐ Yes ☐ No If yes, how much? _____

Does client have a payee? ☐ Yes ☐ No Does client have a savings/checking account? ☐ Yes ☐ No

Has client ever served in the United States Military? ☐ Yes ☐ No

Is client eligible for Military/Veterans benefits? ☐ Yes ☐ No

Transportation:

Does client own a vehicle? ☐ Yes ☐ No Does client use public transportation? ☐ Yes ☐ No

Criminal Convictions:

	Client:	Other Household Members:	Date of Conviction:
Drug-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Production/manufacture of Methamphetamine?	☐ Yes ☐ No	☐ Yes ☐ No	
Violence-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Registered as a sex offender?	☐ Yes ☐ No	☐ Yes ☐ No	
Arson?	☐ Yes ☐ No	☐ Yes ☐ No	

Print Client Name _____ IS # _____

DMH /

Agency/Program

Independent Living Supports/Assistance Needed:

Temporary	Ongoing	
☐	☐	Bathing
☐	☐	Care of personal hygiene
☐	☐	Cooking/preparing foods
☐	☐	Laundry
☐	☐	Housekeeping/cleaning
☐	☐	Making/keeping the home safe
☐	☐	Accessing healthcare and medical issues
☐	☐	Grocery shopping
☐	☐	Public/private transportation
☐	☐	Budgeting/banking/money management
☐	☐	Social skills/interpersonal relationships
☐	☐	Exhibiting appropriate behaviors as outlined in lease agreement
☐	☐	Accessing services in crowded places
☐	☐	Paying rent
☐	☐	Maintaining important personal documents and files
☐	☐	Walking a reasonable distance
☐	☐	Ability to wait in line for services
☐	☐	Using public facilities (i.e., post office)

Housing Plan:

How much can client afford to pay in rent? ☐ $0-$300 ☐ $301-$600 ☐ $601-$1,000 ☐ $1,001+

Who will live with the client? _____

_____ Number of minor children _____ Number of adults _____ Number/kind of pets

Does client have a poor credit history? ☐ Yes ☐ No

Does client have financial resources to pay for move-in expenses? ☐ Yes ☐ No

Does client need household furnishings/appliances? ☐ Yes ☐ No

Where does client want to live? Service Area: _____ City: _____

Does anyone in the client's family have physical limitations that would require accommodations? ☐ Yes ☐ No

If yes, what accommodations? _____

Mark all of the following housing situations that client would consider to be acceptable:

Co-Ed environment?	☐ Yes ☐ No	Sharing a unit/room with another family or individual?	☐ Yes ☐ No
Emergency shelter?	☐ Yes ☐ No	Shared or collaborative housing?	☐ Yes ☐ No
DMH Temporary Shelter Program?	☐ Yes ☐ No	Residential drug treatment program?	☐ Yes ☐ No
Sober living home?	☐ Yes ☐ No	Apartment unit/SRO?	☐ Yes ☐ No

In what ways does client need help in locating housing? ☐ Housing referrals ☐ Housing search ☐ Transportation ☐ Completing application ☐ Other _____

Has client ever been evicted from non-subsidized housing? ☐ Yes ☐ No

If yes, how many evictions has client had in the last 10 years? _____

Is client interested in applying for any of the following permanent housing options?

☐ Homeless Section 8 ☐ Shelter Plus Care (SPC) ☐ Section 8 ☐ Project Based Section 8/SPC housing

If yes, complete the questions on the following page:

Shelter Plus Care (SPC) or Homeless Section 8 Eligibility Assessment *(Only Complete If Applicable)*:

Does the client meet HUD homeless criteria (reside in a place not fit for human habitation such as the streets, a park, a car, abandoned buildings, etc., an emergency shelter, transitional housing for clients who originally came from the streets or an emergency shelter, any of these but is spending a short time in a hospital or other institution, residing in a hospital or institution longer than 30 days if there is no discharge plan and the person would be homeless upon discharge, living in a private dwelling and be within one week of a sheriff's eviction with no resources or subsequent residence identified)?

☐ Yes ☐ No

Has the client been HUD homeless for a continuous year or longer? ☐ Yes ☐ No

Has client ever been evicted from a Governmental subsidized housing program (Sec. 8, SPC etc.)? ☐ Yes ☐ No

If client is currently homeless, how many episodes of HUD homelessness has s/he had in the last three years?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Is client a US citizen or legal resident? ☐ Yes ☐ No

Does client reside in:

A place not meant for human habitation such as the streets, a car, abandoned buildings, parks, bus stations, doorways, etc.? ☐ Yes ☐ No

A homeless shelter? ☐ Yes ☐ No

Transitional or supportive housing for homeless persons who originally came from the streets or a homeless shelter? ☐ Yes ☐ No

Any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution and would otherwise sleep in the types of places described above? ☐ Yes ☐ No

A hospital or institution longer than 30 days if there are no resources available or discharge plan in place and the individual will be homeless when discharged? ☐ Yes ☐ No

A private dwelling and be within one week of a Sheriff's eviction (has eviction papers) with no subsequent residence identified, and lacks the resources and support networks to obtain housing? ☐ Yes ☐ No

Is client fleeing from domestic violence? ☐ Yes ☐ No

Shelter Plus Care is designed for clients who need intensive supportive services such as those in Full Service Partnerships (FSP).

Is the client expected to receive approximately $12,000/yr. worth of ongoing supportive services for at least 5 years? ☐ Yes ☐ No

If the client wants to apply for Homeless Section 8:

Will s/he be receiving supportive services for at least 1 year after lease up? ☐ Yes ☐ No

Is client willing to have at least 4 housing visits in the 1st year of occupancy? ☐ Yes ☐ No

What is the client's housing goal? _____

What have been/are barriers to permanent housing? _____

What are the steps/plan to help client achieve housing goal (include how barriers will be addressed)?

_____

_____

_____

_____

_____ _____

Print Client Name IS #

DMH /

_____

Agency/Program

Provider Signature: _____ Client Signature: _____

HMIS Intake and Enrollment Form

Client Name / ID: _____

Identification *- All fields required unless otherwise noted*

HMIS consent? ☐ No (refused) ☐ Written ☐ Verbal (HFSS only) If verbal: Agency_____ Staff_____ Date _____

First Name: _____ **Middle Name** (Optional)**:** _____

Last Name: _____ **Suffix** (Optional)**:** _____

Name Data Quality: Did the client provide their full name?	**Physical Description** (Optional)**:**	**Last Known Permanent Address:** Where have you last lived for 90 days or more? (Not including emergency shelters and transitional housing)
☐ Full Name Reported ☐ Partial, street name, or code name reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected		Address: _____ City: _____ County: _____ State: _____ Zip: _____ Address Quality: ☐ Full Address Reported ☐ Incomplete or Estimated Address Reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
Date of Birth:	**SSN:**	
_____/_____/_____ ☐ Full DOB reported ☐ Approximate or partial DOB reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	_____-_____-_____ ☐ Full SSN reported ☐ Approximate or partial SSN reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

Contact Information *- Optional but extremely helpful*

Phone Number (*Do you have a number and email where I can follow-up with you or leave a message?)*	**Phone Type**	**Contact Preference**
Main: (_____)_____-_____ x_____ ☐ Leave message	☐ Home ☐ Work ☐ Cell ☐ Message Center	☐ Phone ☐ Text ☐ Email
Alternate:(_____)_____-_____ x_____ ☐ Leave message	☐ Home ☐ Work ☐ Cell ☐ Message Center	
Email _____@_____	**Notes**	

Demographics *- All fields required unless otherwise noted*

Housing Status:		**Family Type:**
☐ Category 1 - Homeless ☐ Category 2 – At Imminent Risk of Losing Housing (within 14 days or less) ☐ Category 3 – Homeless only under other Federal Statutes ☐ Category 4 – Fleeing Domestic Violence ☐ At Risk of Homelessness ☐ Stably Housed	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	☐ Unaccompanied ☐ Single Parent ☐ Two Parents ☐ Adults No children

TB Clearance Date (Optional)	**Clinic Providing Clearance** (Optional)

HMIS Intake and Enrollment Form

Client Name / ID: _____

Relation *(to Head of Household)*	**Gender:**	
☐ Self	☐ Male	☐ Client Doesn't Know
☐ Head of Household's Child	☐ Female	☐ Client Refused
☐ Head of Household's Spouse or Partner	☐ Transgender Female to Male	☐ Data not Collected
☐ Head of Household's other Relation Member	☐ Transgender Male to Female	
☐ Other: Non-relation Member	☐ Doesn't identify as male, female, or transgender	

Disabled? *(Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, Substance Abuse)*	**Veteran** (Have you ever served in the U.S. Military?)	**Education Level** (What is the highest level of education you've completed?)	
☐ Yes	☐ Yes*	☐ Less than Grade 5	☐ Associate's degree
☐ No	☐ No	☐ Grades 5-6	☐ Bachelor's degree
☐ Client Doesn't Know	☐ Client Doesn't Know	☐ Grades 7-8	☐ Graduate degree
☐ Client Refused	☐ Client Refused	☐ Grade 12 / High school diploma	☐ Vocational certification
☐ Data not Collected	☐ Data not Collected	☐ School program does not have grade levels	☐ Client Doesn't Know
	**If yes, please administer VA release of information*	☐ GED	☐ Client refused
		☐ Some college	☐ Data not collected

Insurance (Health Insurance Provider) (Check all that apply)		**Ethnicity**	**Residency Status**
☐ HealthNet	☐ L.A. Care	☐ Non-Hispanic	☐ Citizen
☐ Anthem Blue Cross	☐ L.A. Care Health Plan	☐ Hispanic	☐ Permanent Legal Resident
☐ Kaiser Permanente	☐ L.A. Care Health Partners	☐ Client Doesn't Know	☐ Asylee, Refugee, or other Eligible Immigrant
☐ VA	☐ Other	☐ Client Refused	☐ Ineligible Immigrant
☐ Care 1st Health Plan	☐ Unknown	☐ Data not Collected	☐ Client Doesn't Know
	☐ None		☐ Client Refused

Race (Check all that apply)				
☐ Asian	☐ Black or African American	☐ Data not Collected ☐ Native Hawaiian or Other Pacific Islander	☐ Client Doesn't Know ☐ American Indian or Alaska Native	☐ Client Refused ☐ White

Income and Insurance *- All fields required unless otherwise noted*

DPSS ID (Optional): _____ ☐ GAIN Participant (Optional)

Income Source (Check all that apply)	**Stated Income**	**Pay Interval**					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
☐ No financial resources	$	☐	☐	☐	☐	☐	☐
☐ Earned Income *(employment wages / cash)*	$	☐	☐	☐	☐	☐	☐
☐ Unemployment Insurance	$	☐	☐	☐	☐	☐	☐
☐ Supplemental Security Income (SSI)	$	☐	☐	☐	☐	☐	☐
☐ Social Security Disability Income (SSDI)	$	☐	☐	☐	☐	☐	☐
☐ VA Service-Connected Disability Compensation	$	☐	☐	☐	☐	☐	☐
☐ VA Non-Service-Connected Disability Pension	$	☐	☐	☐	☐	☐	☐
☐ Private Disability Insurance	$	☐	☐	☐	☐	☐	☐
☐ Workers Compensation	$	☐	☐	☐	☐	☐	☐
Continued on Next Page →							

HMIS Intake and Enrollment Form

Client Name / ID: _____

☐ Temporary Assistance for Needy Families *(CalWORKs)*	$	☐	☐	☐	☐	☐	☐	
☐ General Assistance (GA) *(General Relief (GR))*	$	☐	☐	☐	☐	☐	☐	
☐ Retirement Income from Social Security	$	☐	☐	☐	☐	☐	☐	
☐ Pension or retirement income from a former job	$	☐	☐	☐	☐	☐	☐	
☐ Child Support	$	☐	☐	☐	☐	☐	☐	
☐ Alimony or other spousal support	$	☐	☐	☐	☐	☐	☐	
☐ Other Source (Specify:_____)	$	☐	☐	☐	☐	☐	☐	
☐ Client Doesn't Know								
☐ Client Refused								
☐ Data not Collected								

Income Documentation (Optional):

☐ GR Form	☐ CalWORKs Form	☐ Pension Letter/Stub
☐ Pay Stub	☐ Unemployment Insurance Forms	☐ Unemployment Forms
☐ Utility Allowance	☐ W-2 Forms	☐ Self Declaration
☐ Child Support Forms	☐ SSDI Form	☐ Employer Printout/Letter
☐ Social Security Forms	☐ Workmans Comp	☐ VA Documentation
☐ SSI Forms	☐ Self Employment Docs	

Comments (Optional)**:**

Non-Cash Benefits (Check all that apply):

☐ None	☐ Client Doesn't Know	☐ Client Refused	☐ Data not Collected
☐ Food Stamps (CalFresh) Amount: _____	☐ CalWorks Child Care	☐ Temporary Rental Assistance	
	☐ CalWorks Transportation	☐ Section 8 or Rental Assistance	☐ Medically Needy Amount: _____
☐ WIC	☐ Other CalWorks-Funded Services	☐ Other _____	

Health Insurance (Check all that apply)**:**

☐ No Health Insurance		☐ Client Doesn't Know	☐ Client Refused	☐ Data not Collected
☐ Medi-Cal	☐ MEDICARE	☐ State Children's Health	☐ VA Medical Services	☐ Indian Health Services Program
☐ Employer Provided	☐ COBRA	☐ Private Health Insurance		☐ Other: _____

Location Information *- Optional*

Location Type:
On a regular day, where is it easiest to find you?

- ☐ Street
- ☐ Vehicle
- ☐ Abandoned building
- ☐ Bus/train/subway station/airport
- ☐ Drop in center
- ☐ Day services center
- ☐ Soup kitchen
- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Permanent Housing
- ☐ Clinic/Hospital - Health
- ☐ Clinic/Hospital – Mental Health
- ☐ Clinic/Hospital – Substance Abuse
- ☐ Jail, prison, or juvenile detention facility
- ☐ Family or friend's room, apartment, condo, or house
- ☐ Foster care or group home

Address Type
(Enter one: Address, Intersection, or Landmark)**:**

Address: _____

Intersection: _____ and _____

Landmark: _____

City, County, State, and Zip (Enter all)**:**

City: _____

County: _____

State: _____

Zip: _____

Zip Quality: ☐ Full ☐ Client Refused ☐ Client Doesn't Know ☐ Data not Collected

HMIS Intake and Enrollment Form

Client Name / ID: _____

Documentation *- Optional*

Document Type	Obtained Date (If applicable)	Document Status: (If applicable)			Expiration Date (If applicable)
		N/A	Need	Have	
☐ Birth Certificate		☐	☐	☐	
☐ Certificate of Disability		☐	☐	☐	
☐ DD214 (Veterans Only)		☐	☐	☐	
☐ Driver's License / CA ID		☐	☐	☐	
☐ Homeless Verification		☐	☐	☐	
☐ Proof of Residency		☐	☐	☐	
☐ Reference Letter		☐	☐	☐	
☐ Social Security Card		☐	☐	☐	
☐ TB Certification		☐	☐	☐	
☐ Verification of Income		☐	☐	☐	
☐ VA Release		☐	☐	☐	
☐ LACDMH 677 Authorization Consent		☐	☐	☐	
☐ DHS Pre-release		☐	☐	☐	
☐ Other: _____		☐	☐	☐	

Client Note *- Optional*

Client Note:	
Type: ☐ Information ☐ Alert	
Private Customer: ☐ Yes ☐ No	
Note Date: ____/____/____	

Emergency Contact Information *- Optional*

Contact Type	Phone Number	Phone Type	Email
Alternate Contact *(Who is the best person to get in touch with you?)* Relationship: _____ First Name: _____ Last Name: _____	(_____)_____-_____ x_____	☐ Home ☐ Cell ☐ Work ☐ Message Center	
Emergency Contact *(In case of an emergency, who should we alert?)* ☐ Same as above Relationship: _____ First Name: _____ Last Name: _____	(_____)_____-_____ x_____	☐ Home ☐ Cell ☐ Work ☐ Message Center	

Program Entry *- All fields required unless otherwise noted*

Program Name: _____ **Program Entry Date:** _____/_____/_____

Case Manager: _____

HMIS Intake and Enrollment Form

Client Name / ID: _____

HOMELESSNESS – *Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH:

1. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	**2. How long was the client staying in that place?** *(Length of stay in prior living situation)*	**3. Did the client stay less than…**
Literally Homeless Situations ☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter ☐ Safe Haven ☐ Interim Housing	***For literally homeless situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	**Not Applicable** *Go to question 6*
Institutional Situations ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	***For institutional situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***90 days:*** ☐ Yes *Go to question 6* ☐ No *Go to question 10*
Transitional & Permanent Housing Situations ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth) ***Other*** ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***For transitional & permanent housing situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***7 nights:*** ☐ Yes *Go to question 6* ☐ No *Go to question 10*

HMIS Intake and Enrollment Form

Client Name / ID: _____

FOR EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH PROJECTS:

Question	Check One Answer	Comments
4. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter ☐ Safe Haven ☐ Interim Housing ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth) ☐ Client doesn't know ☐ Client refused ☐ Data not collected	
5. How long was the client staying in that place? *(Length of stay in prior living situation)*	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	

After asnwering question 5, go to question 7

If the client is coming from an institution after having stayed less than 90 days or if the client is coming from a transitional, permanent, or other situation after having stayed less than 7 nights, then the following question is required:

Question	Check One Answer	Comments
6. On the night before your current housing situation, did you stay on the streets, in an emergency shelter, or at a safe haven?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

If the project being entered is an emergency shelter, safe haven, or street outreach, or if the client answered questions #4 and #5, then the following questions are required:

Question	Check One Answer	Comments
7. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date started)*	_____/_____/_____	

HMIS Intake and Enrollment Form

Client Name / ID: _____

8. In the past three years, how many times have you returned to the streets, an emergency shelter, or a safe haven after being housed? *(Number of times the client has been on the streets, in ES, or SH in the past three years including today)*	☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times		☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
9. In those three years, what is the total number of months spent homeless on the streets, in an emergency shelter, or in a safe haven? *(Total number of months homeless on the street, in ES, or SH in the past three years)*	☐ One Month (this time is the first month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected

Continue for all clients:

WELLNESS *– All clients, required questions are shaded*

Question	Check One Answer		Comments
10. Have you been diagnosed with AIDS or have you tested positive for HIV?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #10 was answered as "Yes" (*), then the following questions are **required**:			
10a. Do you expect this to substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
10b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
10c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
11. Do you have a chronic health condition? *A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to:* ***heart disease*** *(including coronary heart disease, angina, heart attack and any other kind of heart condition or disease);* ***severe asthma****; diabetes;* ***arthritis-related conditions*** *(including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia);* ***adult onset cognitive impairments*** *(including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions);* ***severe headache/migraine****;* ***cancer****;* ***chronic bronchitis****;* ***liver condition; stroke****; or* ***emphysema****.*	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #11 was answered as "Yes" (*), then the following questions are **required**:			
11a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
11b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
11c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

12. Do you have a physical disability?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #12 was answered as "Yes" (*), then the following questions are **required**:			
12a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
12b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
12c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
13. Do you *currently* have a drug or alcohol problem?	☐ No ☐ Alcohol* ☐ Drug* ☐ Both*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #13 was answered as "Alcohol", "Drug", or "Both" (*), then the following questions are **required**:			
13a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
13b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
13c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
14. Have you ever been told you have a learning disability or developmental disability?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #14 was answered as "Yes" (*), then the following questions are **required**:			
14a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
14b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
14c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
15. Do you feel you currently have a mental health problem?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #15 was answered as "Yes" (*), then the following questions are **required**:			
15a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
15b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
15c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

16. Have you been a victim of domestic violence or a victim of intimate partner violence?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #16 was answered as "Yes" (*), then the following question is **required**:		
16a. How long ago did you have this experience?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to twelve months ago (excluding one year exactly) ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
16b. Are you currently fleeing?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

TUBERCULOSIS *– Emergency Shelters and Winter Shelters only, required questions shaded*

Question	Check One Answer	Comments
17. Do you have a cough that has lasted longer than 3 weeks?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
18. Have you recently lost weight without explanation during the past month?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
19. Have you had frequent night sweats during the past month, soaking your sheets or clothing?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
20. Have you coughed up blood in the past month?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
21. Have you been feeling much more tired than usual over the past month?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
22. Have you had fevers almost daily for more than one week?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	

EMPLOYMENT *- For adults18 and older or Head of Household < 18 years old, required questions shaded*

Question	Check One Answer	Comments
23. Are you currently employed?	☐ No* ☐ Yes** ☐ Client Doesn't Know ☐ Client Refused	
If question #23 was answered as "No" (*), then the following question is **required**:		
23a. Why are you not employed?	☐ Looking for work ☐ Unable to work ☐ Not looking for work	
If question #23 was answered as "Yes" (**), then the following question is **required**:		
23b. What type of employment do you have?	☐ Full-time ☐ Part-time ☐ Seasonal / sporadic (including day labor)	

HMIS Intake and Enrollment Form

Client Name / ID: _____

INCOME *- Adults aged 18 and older having* ***NO*** *financial resources only*

Question	Check One Answer		Comments
24. If you do not have an income, and are unable to receive general relief, what's the reason why?	☐ Sanctioned ☐ Time Limits ☐ Employment	☐ Other	

PREGNANCY *- Women aged 15 and older only*

Question	Check One Answer		Comments
25. Are you pregnant?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused	
If question #25 was answered as "Yes" (*), then the following question is **required**:			
25a. What is your due date?	____/____/_____		

YOUTH *- Head of Households aged 17 and under only*

Question	Check One Answer		Comments
26. Did you run away from home or a foster care home?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	

TRANSITION AGE YOUTH (TAY) *- Head of Households aged 16 to 24 only, required questions are shaded*

Question	Check One Answer		Comments
27. Are you a current or former foster care youth?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
28. Have you ever been in the juvenile justice system?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
29. Have you ever been on adult probation?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
30. Which of the following best represents how you think about yourself?	☐ Straight ☐ Lesbian or Gay ☐ Bisexual	☐ Questioning ☐ Client Doesn't Know ☐ Client Refused	

HMIS Intake and Enrollment Form

Client Name / ID: _____

VETERAN *- US Veterans only, required questions are shaded*

Question	Check One Answer	Comments
31. Which branch of the military did you serve in?	☐ Army ☐ Coast Guard ☐ Air Force ☐ Client Doesn't Know ☐ Navy ☐ Client Refused ☐ Marines ☐ Data not Collected	
32. What type of discharge did you receive?	☐ Honorable ☐ General under honorable conditions ☐ Other than honorable conditions (OTH) ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
33. When did you enter military service?	____/____/_____ ☐ Doesn't Know	

NOTE: The following questions are required for SSVF programs, but HIGHLY recommended to be completed for all veterans.

34. When did you separate from military service?	____/____/_____ ☐ Doesn't Know	
35. What is the AMI percentage for the Household's Income?	☐ Less than 30% ☐ 30% to 50% ☐ Greater than 50%	

Did you serve in any of the following wars/war eras?

36. World War II *Dec. 1941 – Dec. 1946*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
37. Korean War *Jun. 1950 – Jan. 1955*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
38. Vietnam War *Feb. 1961 – May 1975*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
39. Persian Gulf War (Operation Desert Storm) *Aug. 1990 – April 1991*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
40. Afghanistan (Operation Enduring Freedom) *Oct. 2001 - Present*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
41. Iraq (Operation Iraqi Freedom) *Mar. 2003 – Aug. 2010*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
42. Iraq (Operation New Dawn) *Sept. 2010 – Dec. 2011*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
43. Other Peace-keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

SSVF HP TARGETING CRITERIA *- US Veterans only, required for SSVF Prevention programs*

44. Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not meant for human habitation.

☐ No (0 points) ☐ Yes

45. Major change in household composition (e.g., death of family member, separation/divorce from adult partner, birth of new child) in the past 12 months

☐ No (0 points) ☐ Yes

46. Rental Evictions within the Past 7 Years

☐ 4 or more prior rental evictions ☐ 2-3 prior rental evictions ☐ 1 prior rental eviction ☐ No prior rental evictions (0 points)

47. Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit

☐ No (0 points) ☐ Yes

48. History of Literal Homelessness (street/shelter/transitional housing)

☐ 4 or more times or total of at least 12 months in past three years ☐ 2-3 times in past three years
☐ 1 time in past three years ☐ None (0 points)

49. Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing

☐ No (0 points) ☐ Yes

50. Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property

☐ No (0 points) ☐ Yes

51. Registered sex offender

☐ No (0 points) ☐ Yes

52. At least one dependent child under age 6

☐ No (0 points) ☐ Yes

53. Single parent with minor child(ren)

☐ No (0 points) ☐ Yes

54. Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)

☐ No (0 points) ☐ Yes

55. Any Veteran in household served in Iraq or Afghanistan

☐ No (0 points) ☐ Yes

56. Female Veteran

☐ No (0 points) ☐ Yes

57. HP applicant total points

58. Grantee targeting threshold score

USE OF OTHER CRISIS SERVICES *- US Veterans only, required for SSVF programs*

59. Number of visits to an emergency room in the past year

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

60. Approximate number of nights in jail / prison in the past year

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

61. Approximate number of nights spent in an inpatient medical facility in the past year

☐ Never ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

HMIS Intake and Enrollment Form

Client Name / ID: _____

CHRONIC HOMELESSNESS *- Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

Question	Check One Answer	Comments
ASSESSOR ONLY – DO NOT ASK: **44.** Is the respondent chronically homeless? *To be chronically homeless, the client must be an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless* for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time.*	☐ No ☐ Yes	

_____ _____ _____

Client Signature Site Date

_____ _____ _____

Agency Staff Signature Site Date

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name _____ **Last Name** _____

Street Address _____ **City, State, Zip** _____

IS Number _____ **Birth Date** _____ **Phone Number** ( )_____

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Los Angeles & Orange County Homeless Management Information System (LA/OC HMIS).

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in the Section 8 Special Programs application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for the Section 8 Special Program, assistance with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as entering information into the LA/OC HMIS managed by the Los Angeles Homeless Services Authority. This information will also be used to coordinate services and track client information.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: This authorization remains valid until the Section 8 Special Program participant is no longer receiving housing subsidy services through Department of Mental Health's grant with City and/or Housing Authorities.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Countywide Housing, Employment, and Education Resource Development Federal Housing Subsidies Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	**Last Name**
Street Address	**City, State, Zip**
IS Number	**Birth Date**
	( ) Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Housing Authority of the City of Los Angeles (HACLA), Special Program Operations and Administration.

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in HACLA's housing subsidy application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for housing subsidies assistance, with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as providing quarterly and annual reports.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: This authorization remains valid until the housing subsidies program participant is no longer receiving services through Department of Mental Health's grant with HACLA.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Countywide Housing, Employment, and Education Resource Development Federal Housing Subsidies Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

LAC-DMH NOTICE OF PRIVACY PRACTICES: *Acknowledgement of Receipt* Effective Date: September 23, 2013

TRANSLATION ☐ NO ☐ YES

This Acknowledgement was translated into _____ for the client and /or responsible adult*

_____ _____
PRINT NAME OF TRANSLATOR DATE

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County - Department of Mental Health (LAC-DMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-DMH**.**

Signature: _____ Date:_____
(Client/Responsible Adult)

*Responsible Adult = Guardian, Conservator, or Parent of Minor when required (See Minor Consent)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member:_____ Date:_____

Reasons why the acknowledgement was not obtained:

- ☐ Client refused to sign (see progress notes for explanation)
- ☐ Other Reason or Comments:

_____

_____

_____

_____

_____

_____

Los Angeles County –Department of Mental Health
Notice of Privacy Practices

Effective: **September 23, 2013**

NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING /PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting your information. We refer to this information as "Protected Health Information" or "PHI". We create a record of the care and services you receive from Los Angeles County-Department of Mental Health ("LAC-DMH"). We need this record to provide you with quality care and to comply with certain legal and payment requirements.

This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning your PHI; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

We use and disclose PHI in many ways. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories required by law.

For Treatment We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, nursing and medical students, or LAC-DMH personnel who are involved in taking care of you. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some medications may affect your blood pressure. We may share your PHI for treatment in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

For Payment We may use and disclose PHI about you so that the treatment and services you receive at LAC-DMH may be billed and payment may be collected from you or on your behalf from an insurance company or a third party. For example, we may need to give your health plan information about testing that you received at our facilities so your health plan will pay us or reimburse you for those services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose PHI about you for our LAC-DMH business operations. These uses and disclosures are necessary to run our organization and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also gather PHI about many of LAC-DMH clients to decide what additional services our facilities should offer, what

services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, nursing and medical students, and other personnel for review and learning purposes. We may also compare the PHI we have with PHI from other organizations and providers to determine how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the identify of any clients.

For Appointment Reminders We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at LAC-DMH clinics.

For Your Own Information We may use and disclose PHI to tell you about your own health condition, such as your test results, to tell you about or recommend possible treatment options or alternatives, and to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care We may disclose PHI about you to a family member or other person you designate if you give us permission to do so. We may also tell certain family members about your presence in our facility but only if the law permits us to do so. We may share PHI about you when necessary for a claim for aid, insurance, or medical assistance to be made on your behalf.

For Health Information Exchange (HIE)We, along with other health care providers in the Los Angeles area, participate in one or more health information exchanges. An HIE is a community-wide information system used by participating health care providers to share health information about you for treatment purposes. Should you require treatment from a health care provider that participates in one of these exchanges who does not have your medical records or health information, that health care provider can use the system to gather your health information in order to treat you. For example he or she may be able to get laboratory or other tests that have already been performed or find out about the treatment that you have already received. We will include your PHI in this system.

For Research

Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process, but we may, disclose PHI about you to people preparing to conduct a research project, for example, to help them look for clients with specific medical needs. We will always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law We will disclose PHI about you when required to do so by federal, State or local law, such as laws that require us to report abuse.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Provide Breach Notification We may use and disclose your PHI, if necessary, to tell you and regulatory authorities or agencies of unlawful or unauthorized access to your PHI. For example, if your PHI is lost or stolen.

SPECIAL SITUATIONS WHEN WE MAY USE OR DISCLOSE PHI/PHI ABOUT YOU:

Workers' Compensation We may release PHI about you for workers' compensation or similar programs to comply with these and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose PHI about you when required for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of product recalls of the products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect We may disclose PHI about you to a public health authority that is authorized by law to receive reports of child abuse or neglect. We may also disclose your PHI if we believe that you have been a victim of elder or dependent adult abuse or neglect provided the disclosure is authorized by law.

Lawsuits and Dispute If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the privacy of the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- in response to a court order, court-issued subpoena, court- issued warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization;
- about criminal conduct at LAC-DMH facilities; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

Protective Services for the President and Others We may disclose PHI about you to authorized federal or government law enforcement officials so they may provide protection to the President, other authorized or elected persons or foreign heads of state or to conduct special investigations.

Protection and Advocacy Services We may disclose PHI about you to the protection and advocacy agency established by law to investigate incidents of abuse and neglect and to otherwise protect the legal and civil rights of people with disabilities.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official we may disclose PHI about you to the correctional institution or law enforcement official. This disclosure would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your PHI that is used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the facility where you are receiving treatment/services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If your health information is available electronically, under certain circumstances, you may be able to obtain this information in an electronic format. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to PHI, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by LAC-DMH will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

Right to Amend If you feel that PHI we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all of the information, both old and new, is kept by or for LAC-DMH. To request an amendment, your request must be made in writing and submitted to the LAC-DMH facility where the information is in question. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- is not part of the PHI kept by LAC-DMH;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you, excluding disclosures for the purpose of treatment, payment or healthcare operations. To request this list or accounting of disclosures, you must submit your request in writing to LAC-DMH or we will provide you with a form to make your request. Your request must state a time period, which may not be more than six years prior to your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12- month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member. We will do our best to honor your request; however, except when you fully pay out-of-pocket as explained below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing or we will provide you with a form to make your request. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right To Restrict Disclosure of Information For Certain Services You have the right to restrict the disclosure of information regarding services for which you or someone else has paid in full or on an out-of-pocket basis (in other words you don't ask us to bill your health plan or health insurance company). If you or someone else has paid in full for a service, we must agree to your request and we will not share this information with your health plan without your written authorization, unless the law requires us to share your information.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to LAC-DMH or we will provide you with a form to make your request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to honor your request.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any of our office staff. You may obtain a copy of this Notice at our website: http://dmh.lacounty.gov/

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or you may request one from one of our facilities.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the U.S. Department of Health & Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, please contact:

Los Angeles County Department of Mental Health (LAC-DMH)
Patients' Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020
(213) 738-4949

To file a complaint with Los Angeles County, contact:

Los Angeles County Auditor-Controller
HIPAA Compliance Unit
500 West Temple Street, Suite 515
Los Angeles, CA 90012
(213) 974-2164
Email: HIPAA@auditor.lacounty.gov

To file a complaint with the Federal Government, contact:

Region IX, Office for Civil Rights,
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (800) 537-7697

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

SHELTER PLUS CARE PROGRAM
SERVICE PROVIDER RESPONSIBILITY FORM

To be completed and signed by the Program/Agency Manager:

Name of Participant: _____

Name of Agency: DMH /

The program manager will ensure that the Shelter Plus Care (SPC) participant will have an assigned case manager who will be responsible for the following for the duration of client participation in the program:

- Assist the client with completing the required documents by the Housing Authority of the City of Los Angeles (HACLA) or Housing Authority of the County of Los Angeles (HACoLA) and accompany the participant to the scheduled meetings with Housing Authorities.

- Assist the client in a housing search.

- Send signed lease agreements to the Federal Housing Subsidies Unit (FHSU) when received.

- Ensure that the agency remains updated regarding participant's current contact information.

- Maintain, at a minimum, monthly contact with the participant and quarterly home visits.

- Conduct needs assessments to determine appropriate linkage to community-based services such as health care, childcare, alcohol and other substance abuse, education and/or job training, and other services essential for achieving and maintaining independent living.

- Conduct ongoing assessments/evaluations to monitor progress and provide appropriate interventions as needed.

- Provide a Housing Annual Assessment form that incorporates the current housing goal to ensure compliance with housing contracts between DMH and the Housing Authorities. This should be submitted to FHSU each year on the anniversary of the lease up date.

- Update the participant's Client Care Coordination Plan (CCCP) annually and include any appropriate housing-related goals.

- Submit signed MH 677, Authorizations for Request and Use/Disclosure of Protected Health Information (PHI) to allow DMH to disclose PHI to the Housing Authority (MH 677 HACLA or MH 677 HACoLA) and to the Los Angeles Homeless Services Authority/Homeless Management Information System (MH 677 HMIS), and a signed MH 601E, Acknowledgement of Receipt of the LACDMH Notice of Privacy Practices.

- Comply with all requirements of McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.) including that they ensure and monitor that households with school-aged minors are enrolled in school and receive entitled benefits.

- Complete all required reports and any other requested documentation including the Quarterly Report Survey (HACLA) and Client Progress Report - Quarterly Review (HACoLA). These records will be subject to audit by HUD and the local Housing Authority administering the grant.

- Participate in regularly scheduled Housing Liaison meetings to obtain updates on program requirements.

- Assist the client with completing his/her paperwork for the Annual Recertification Packet (HACLA) or Annual Re-exam Packet (HACoLA).

- If the participant is transferred to another directly-operated or contracted DMH agency/program, ensure that the new program is aware that the client is a SPC participant and that they understand the requirements of the program by gaining the signature of the new Program Manager on the Service Provider Responsibility form and submitting it to FHSU.

- Notify FHSU if the participant abandons his/her unit, is deceased, or terminated from SPC.

Print Program/Agency Manager's Name: _____

Program/Agency Manager's Signature: _____

Date: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SHELTER PLUS CARE PARTICIPANT AGREEMENT

As a participant in the Shelter Plus Care (SPC) Program with the Housing Authority of the City of Los Angeles (HACLA) or Housing Authority of the County of Los Angeles (HACoLA), **I agree to abide by the following program expectations**:

1. Maintain contact and meet, as necessary, with my case manager at a minimum of once monthly for as long as I am a participant in the SPC Program.
2. Participate in the development of the Client Coordination Care Plan (CCCP) with my service provider team to pursue my recovery goals.
3. Participate in supportive services to pursue my recovery goals including vocational and educational assistance, life skills classes, budget and money management classes, nutritional planning, and any other supportive services as deemed necessary.
4. Receive quarterly home visits from my service provider team.
5. Abide by the terms of my lease agreement.
6. Provide a signed lease agreement to my service provider team in a timely manner.
7. Provide my service provider team with updated contact information (phone number, address, emergency contact. etc).
8. If applicable, provide my service provider team with information about any school-aged minors in my household and whether they are enrolled in school and receiving entitled benefits so that DMH can be in compliance w/ McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.).
9. _____
   _____
10. _____
    _____

Print Client's Name: _____

Client's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____

Translated by: _____ Date: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

AFFORDABLE CARE ACT CERTIFICATION FORM

To be completed and signed by the Case Manager:

Our agency / program certifies that we are ensuring this program participant is assisted in applying for ACA Health Benefits, if appropriate (or officially opting out) and maintaining documentation indicating if the assistance was provided and completed on-site or if a referral was made to an off-site agency.

☐ Check here if participant already has health insurance such as Medi-Cal or Medicare

Name of Participant: _____

Name of Agency: DMH / _____

Print Case Manager's Name: _____

Case Manager's Signature: _____

Date: _____

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

ACKNOWLEDGEMENT OF RECEIPT
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

- Go to school, even if they do not have a permanent address
- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
- Have access to the same services and programs that are available to all other students
- Receive transportation to school from their current residence
- Automatically be enrolled in free lunch or free meal programs

The following resources can assist you to access educational benefits for your family:

Los Angeles County Office of Education Website:
http://www.lacoe.edu/StudentServices/HomelessFosterYouth/HomelessChildren

Los Angeles County Office of Education Contact
Melissa Schoonmaker
School Attendance Review Board/McKinney-Vento Homeless Education Program Manager
Email: homeless_program@lacoe.edu
Phone: (562) 922-6233 Fax: (562) 922-6781
Student Support Services - Education Center West (formerly Clark)
12830 Columbia Way, ECW-3236, Downey, CA 90242

Los Angeles Unified School District (LAUSD):

LAUSD Web site
http://homelesseducation.lausd.net/

LAUSD Contact
Angela Chandler, Pupil Service and Attendance Coordinator
Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

I acknowledge receiving this notice and the attached bulletin: _____
Print Name

_____ _____
Signature Date

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

NOTICE TO HOUSEHOLDS WITH SCHOOL-AGE YOUTH
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

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- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
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LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

You can ENROLL in school!

Even if you have:

- **Uncertain housing**
- **A temporary address**
- **No permanent physical address**

You are guaranteed enrollment in school by the federal McKinney-Vento Act and California state law if you live:

- In a shelter (family, domestic violence, or youth shelter or transitional living program)
- In a motel, hotel, or weekly rate housing
- In a house or apartment with more than one family because of economic hardship or loss
- In an abandoned building, in a car, at a campground, or on the street
- In temporary foster care or with an adult who is not your parent or guardian
- In substandard housing (without electricity, water, or heat)
- With friends or family because you are a runaway or an unaccompanied youth

To enroll in or attend school if you live under any of these conditions, you do NOT need to provide:

- Proof of residency
- Immunization records or tuberculosis skin-test results
- School records
- Legal guardianship papers

You may:

- Participate fully in all school activities and programs for which you are eligible.
- Continue to attend the school in which you were last enrolled even if you have moved away from that school's attendance zone or district.
- Receive transportation from your current residence back to your school of origin.
- Qualify automatically for child nutrition programs (free and reduced-price lunches and other district food programs).
- Contact the district liaison to resolve any disputes that arise during the enrollment process.

Parents' responsibilities are to:

- Make sure your child attends school regularly and completes homework and projects on time.
- Attend parent/teacher conferences, Back-to-School Nights, and other school-related activities.
- Stay informed of school rules, regulations, and activities.
- Participate in school advisory/decision-making activities.

For questions about enrolling in school or for assistance with school enrollment, contact:

Your local school district liaison:

Nancy Gutierrez
Pupil Service and Attendance Coordinator
LAUSD Homeless Education Program,
Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012
Phone: 1-213-202-7581

Your county liaison for the homeless:

Melissa Schoonmaker
Homeless Education Program Manager
School Attendance Review Board /
McKinney-Vento
12830 Columbia Way, ECW-3236
Downey, CA 90242
Phone: 1-562-922-6233

Your state coordinator for the homeless:

Leanne Wheeler
State Coordinator
California Department of Education
1430 N Street, Suite 6208
Sacramento, California 95814
Phone: 1-866-856-8214

California Department of Education

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
FEDERAL HOUSING SUBSIDIES UNIT
CITY SHELTER PLUS CARE PROGRAM

Sample Format for Case Manager / Housing Liaison Referral Letter

Must be on Agency letterhead.

First Paragraph

- Just one or two sentences describing your agency's program(s) (Attaching an agency brochure helps.)
- Applicant's entry date into your agency's program
- Applicant's exit date from your agency's program. (If applicable, explain why the Applicant is leaving your agency's program, and identify the linkage schedule and the next provider to whom Applicant will be linked--agency name, case manager name and phone number.)
- Say where the applicant is living at the present time.
    - If he or she is in a shelter or transitional living program, ask the shelter to write a letter on their letterhead (and add their pamphlet, if available).
    - If the applicant is living on the "streets," include information specifying where he or she can be found (e.g., "Ms. Jones resides in the alley directly behind the Baja Fresh Restaurant located at 6043 Hollywood Boulevard, Hollywood, CA 90028. I have met with her for case management at this location on the following dates: 01/23/04, 02/06/04, 03/10/04, and 04/13/04. She was noted by police citation for sleeping in this alley on the flowing dates: 05/23/04, and 05/30/04."

Troubleshooting

- If exit date at shelter or transitional living program has passed, then explain why the Applicant is still in the program.
- *Example*: "Even though Mr. Smith's residential time at Hugh Heffner's Transitional Living Center has expired, we received permission to allow him to stay here until he is approved for a City Shelter Plus Care Certificate. "
- Be mindful if you allow an Applicant to stay at your facility past their expiration date (i.e., identify why and for how long).

Second Paragraph

- Narrative outline of the Applicant's homeless history, with **NO** time gaps.
- Identify time periods Applicant can't recall, if any.
- This detailed history should begin from when Applicant began seeing the case manager. If that time is less than two years, then the case manager should include the Applicant's recollection of their homelessness prior to engagement.
- Include (1) the specific date Applicant first became homeless and (2) the event that caused Applicant's to become homeless. If the event is documented (e.g.,

eviction papers, motel receipts, etc.) reference them here and include them in the application.
- Identify and explain **all** Applicant telephone numbers and addresses disclosed **anywhere** in the application package, including the address on the Applicant's CDL or other photo ID.
- Explain why Applicant cannot live at / return to these addresses

Third Paragraph
- Explain why you think this Applicant meets target population for Shelter Plus Care (Remember: the Applicant has to be sick enough to meet the service match).
- Mental illness should only be mentioned (e.g., "Mr. Burnett has a mental illness, attends all appointments regularly at the clinic, and is medication compliant.")
- Explain your Applicant's experience with your program
- Always include strengths and positive points concerning the applicant
- Mention Independent Living Skills, especially money management. (Place the person you have chosen for a Shelter Plus Care Certificate into a Community Living Program or Independent Living Skills class.)

Fourth Paragraph
- If children are involved, please state: (1) where they are, (2) who is supporting them, and (3) if the child is in placement, attach court paperwork indicating who has custody and a letter from the Children's Social Worker indicating that the child will be allowed to reside with the applicant in the apartment.
- Criminal Background Checks: Criminal background checks are required for all adult family members (18 years and over) that will be residing with the applicant. Provide information concerning the following:
    - If the adult family member has been convicted of any drug or alcohol related offense, explain and document what treatment (including residential and out patient substance abuse treatment, 12-step meetings, etc.) he or she has been involved in and completed.
    - If the adult family member has been convicted of a violent offence, explain and document what treatment (including anger management classes, and individual therapy, etc.) he or she has been involved in and completed.
- NO CRIMINAL BACK GROUND CHECK HAS BEEN ASKED FOR THE APPLICANT FROM HACLA (Housing Authority of the City of Los Angeles). This information is collected elsewhere in the application and does not need to be mentioned in the referral letter.

Fifth Paragraph
- Closing remarks and contact information for referring clinician or case manager.

Salutation,

Signature
Title

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

SAMPLE REFERRAL LETTER

November 1, 2016

Eligibility Interviewer
Housing Authority of the City of Los Angeles
Special Programs Operation
2600 Wilshire Blvd., 2nd Floor
Los Angeles, CA 90057

RE: Jane Doe, SS# 123-45-6789

Housing Authority of the City of Los Angeles:

I am writing this letter in support of Jane Doe's Shelter Plus Care application. Jane has been a client of the ACTION program since October 18, 2012. ACTION is an assertive community treatment program that assists dually diagnosed consumers with psychotherapy, case management, and psychiatry. Jane has a mental illness and has maintained all scheduled appointments with me for counseling and sees her psychiatrist regularly despite her lack of a fixed nightly residence.

Jane became homeless on January 8, 2013 after fleeing from a domestic violence situation. For the past four years, Jane has lived in inpatient psychiatric hospitals, on the street, crisis residential facilities, LAHSA cold/wet weather shelters, and a garage. We recently met and reviewed her psychiatric treatment history and compiled the following list of dates and locations of Jane's living arrangements. Because of the client's cognitive deficits and memory loss, the following represents the best history this client can recollect:

01/08/2013 to 02/07/2013: 1736 Crisis House, Torrance, CA 90000
02/08/2013 to 03/15/2013: New Image Emergency Shelter, Los Angeles, CA 90000
03/16/2013 to 06/31/2013: Shady Lady Motel, 3434 Sunset Blvd., Hollywood, CA 90000
07/01/2013 to 08/31/2013: Client does not remember where she resided
09/01/2013 to 10/25/2013: Twin Towers Correctional Facility
10/26/2013 to 12/15/2013 "Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
12/16/2013 to 12/19/2013: BHC Hospital, Psychiatric Unit, Rosemead, CA 90000
12/20/2013 to 01/19/2014: Excelsior House Crisis Residential Treatment, LA, CA 90000
01/20/2014 to 04/01/2014: "Streets" – Car parked at 1720 E 120th St., Los Angeles, CA 90000 (Car was towed)

04/02/2014 to 04/15/2014: "Streets" – Alley between Augustus Hawkins MHC and King Drew Medical Center, Los Angeles, CA 90000
04/16/2014 to 06/20/2014: Help is on the Way Shelter, Los Angeles, CA 90000
06/21/2014 to 07/26/2014: Client does not remember where she resided
07/27/2014 to 08/05/2014: Brotman Medical Center, Psychiatric Unit, LA, CA 90000
08/06/2014 to 12/15/2014: "Streets" – 2nd and Broadway, Santa Monica, CA 90000
12/16/2014 to 03/15/2015: New Directions Emergency Shelter, West LA, CA 90000
03/16/2015 to 04/10/2015: Weingart Center Shelter, Los Angeles, CA 90000
04/11/2015 to 08/04/2015: "Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
08/05/2015 to 08/08/2015: Robert F. Kennedy, Psychiatric Unit, Los Angeles, CA 90000
08/09/2015 to 02/09/2016: Daybreak Transitional Living Program, SM, CA 90000
02/10/2016 to 05/06/2016: Garage/Abandoned Home -- 1796 Raymond St., Los Angeles, CA 90000. The garage lacked cooking facilities, a restroom or shower, running water, electricity, and insulation to keep warm. The roof often leaked when it rains.
05/07/2016 to 05/22/2016: Twin Towers Correctional Facility – Arrested for trespassing
05/23/2016 to 06/15/2016: "Streets" – near Cherokee and Hollywood Blvd., Hollywood, CA 90000
06/15/2016 to 09/15/2016: Jan Clayton Center Residential Substance Abuse Treatment, Hollywood, CA 90000
09/16/2016 to present: PATH Specialized Shelter Bed Program, LA, CA 90000

Jane is an appropriate candidate for the Shelter Plus Care program because she is now medication compliant, has completed courses in parenting, independent living skills, and money management. In the past, Jane successfully maintained a residence and has good independent living skills. Jane is a part of the Money Management Program at Hollywood Mental Health Center, which will also continue to provide the intensive case management that will allow her to maintain independence in the community. In addition, Jane has completed a 90-day residential substance abuse treatment program and continues to maintain a relationship to her facility by attending outpatient groups. Jane also attends 12 Step groups for support and fellowship in recovery.

Jane has an 8-year-old daughter (Sheila Doe) who will live with her mother once she is in a stable living situation. Presently, Sheila resides with client's mother (Marie Doe) at 6703 67th Street, Los Angeles. A letter from client's DCFS social worker indicating the child's current location and the social worker's intent to place the child with client at her new residence is attached.

I appreciate your time in reviewing this case. A Shelter Plus Care certificate would provide an avenue of stability for Jane. If you have any questions or concerns, please feel free to call me at 213-637-5555.

Sincerely,

Daisy Obetsanov, MSW
Psychiatric Social Worker

PLACE HERE

To get a copy of the **HOUSING AUTHORITY SPECIAL PROGRAMS APPLICATION FOR RENTAL ASSISTANCE (11pgs)**, please contact Federal Housing Subsidies Unit (FHSU) to arrange pick up.

Please contact:

Martha Ortiz at
mortiz@dmh.lacounty.gov

Client No:

HOUSING AUTHORITY

DECLARATION OF CITIZENSHIP/ELIGIBLE IMMIGRATION STATUS

INSTRUCTIONS: In order to be eligible to receive housing assistance, each resident/program applicant must be within the United States lawfully. Please read the certification carefully and return it as directed. Each family member who is age 18 or older must sign a Certification form The responsible adult who will be living in the unit must sign the Certification form for all family members under the age of 18.

I CERTIFY THAT, under the penalty of perjury, to the best of my knowledge, I am lawfully within the United States because (please check the appropriate boxes):

A. ☐ I am a citizen, naturalized citizen, or a national of the United States.
B. ☐ I have eligible immigration status.
Alien Registration No. _____

I CERTIFY THAT:

C. ☐ I do not have eligible immigration status.
D. ☐ I choose not to state my immigrant status.
E. ☐ I am signing the Certification on behalf of minors(s):

Minor's Name	Birth Date	Relationship	Citizenship Status (select the letter that corresponds with the statement above)	Alien Registration
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ I am signing the certification on behalf of adult family member(s) who do not have eligible immigration status or do not choose to state their immigration status *(head of household or spouse must be a citizen or have eligible immigration status to certify under this category):*

Family Member's Name	Birth Date	Relationship	Citizenship Status (select the letter that corresponds with the statement above)
			C D
			C D
			C D

WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLFULLY MAKING FALSE OR FRAUDULENT STATEMENTS OR REPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES. IN ADDITION, MAKING FALSE STATEMENTS IS A FELONY UNDER CALIFORNIA STATE LAW (PENAL CODE SECTIONS:115, 118, 487 AND 532) AND MAY RESULT IN CRIMINAL CHARGES INCLUDING BUT NOT LIMITED TO: PERJURY, GRAND THEFT, FILING FALSE DOCUMENTS WITH A PUBLIC OFFICE AND OBTAINING MONEY UNDER FALSE PRETENSES.

SECTION 487i OF THE CALIFORNIA PENAL CODE STATES THAT ANY PERSON WHO DEFRAUDS A HOUSING PROGRAM OF A PUBLIC HOUSING AUTHORITY OF MORE THAN FOUR HUNDRED DOLLARS ($400) IS GUILTY OF GRAND THEFT.

_____ _____ _____

Print Name Signature Date

Client No:

AUTORIDAD DE VIVIENDA

DECLARACIÓN DE CIUDADANÍA/ESTADO INMIGRATORIO ELEGIBLE

INSTRUCCIONES: A fin de reunir los requisitos legales para continuar recibiendo asistencia de vivienda, cada residente o participante del programa debe radicar en los Estados Unidos legalmente. Favor de leer la certificación cuidadosamente y devuélvala como se indica. Todo miembro de la familia que sea mayor de 18 años de edad debe firmar un formulario de certificación. El adulto responsable que va a residir en la vivienda debe firmar el formulario de certificación por todos los miembros de la familia que sean menores de 18 años.

CERTIFICO QUE, bajo pena de perjurio y según mi leal saber y entender, radico legalmente en los Estados Unidos porque (favor de marcar las casillas pertinentes):

A. ☐ Soy ciudadano de los Estados Unidos, ciudadano naturalizado o por nacimiento.
B. ☐ Tengo un estado elegible de inmigración.
Número de cédula _____.

CERTIFICO QUE:

C. ☐ No tengo estado elegible de inmigración.
D. ☐ Opto por no declarar mi estado de inmigración.
E. ☐ Firmo la certificación por parte de un menor o menores:

Nombre del menor	Fecha de Nacimiento	Parentesco	Estado de ciudadanía (seleccione la letra que corresponde con la frase anterior)	Número de cédula
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ Firmo la certificación a nombre de miembros adultos de la familia que no tienen estado elegible de inmigración u optan por no declarar su estado de inmigración *(el jefe de familia o cónyuge debe ser ciudadano o tener estado elegible de inmigración para certificar en esta categoría)*:

Nombre del familiar	Fecha de nacimiento	Parentesco	Estado de inmigración (seleccione la letra que corresponde con la frase anterior)
			C D
			C D
			C D

ADVERTENCIA: EL TÍTULO 18, SECCIÓN 1001 DEL CÓDIGO DE LOS ESTADOS UNIDOS ESTABLECE QUE UNA PERSONA ES CULPABLE DE UN DELITO GRAVE SI A SABIENDAS Y POR VOLUNTAD PROPIA HACE DECLARACIONES FALSAS O FRAUDULENTAS A UN DEPARTAMENTO U OFICINA DE LOS ESTADOS UNIDOS. HACER DECLARACIONES FALSAS ES UN DELITO GRAVE BAJO LA LEY DEL ESTADO DE CALIFORNIA (CÓDIGO PENAL SECCIONES: 115, 118, 487 Y 532) Y PUEDE TRAER COMO CONSECUENCIA CARGOS PENALES, INCLUYENDO PERO NO LIMITADO A: PERJURIO, HURTO MAYOR, ENTREGAR DOCUMENTOS FALSOS A UNA OFICINA PÚBLICA Y OBTENER DINERO DE MANERA FRAUDULENTA.
EL ARTÍCULO 487i DEL CÓDIGO PENAL DEL ESTADO DE CALIFORNIA ESTABLECE QUE TODA PERSONA QUE DEFRAUDE A UN PROGRAMA DE UNA AUTORIDAD DE VIVIENDA POR MÁS DE CUATROCIENTOS DÓLARES ($400) ES CULPABLE DE ROBO MAYOR.

_____ _____ _____

Nombre en letra de molde Firma Fecha

HOUSING AUTHORITY

Client No:

CONSENT FORM TO VERIFY IMMIGRATION STATUS WITH THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS)

CONSENT: I consent to allow the Housing Authority to request and to obtain information from the U.S. Citizenship and Immigration Services (USCIS) for the purpose of verifying my eligibility and level of benefits under the Housing Authority's assisted housing programs. I understand that the Housing Authority cannot use it to delay, deny, or terminate housing assistance because of the immigration status of a family member, except as provided in the Department of Housing and Urban Development (HUD) regulations. In addition, I understand I must be given an opportunity to contest the determination with the USCIS or the Housing Authority or both.

Signatures:

ADULT(S): AGE 18 OR OVER

Head of Household (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Spouse (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date

MINOR(S): UNDER AGE 18

Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date

Who Must Sign: In order to be eligible to receive housing assistance, each noncitizen adult or minor applying for, or currently receiving, housing assistance must be lawfully within the U.S. Please read the Verification Consent Form carefully and sign and return as directed. Please feel free to consult with an immigration lawyer or other Immigration expert of your choosing.

Privacy Act Statement: The information on this form is being collected by Housing Authority to determine the applicant's or participant's eligibility for housing assistance. The Housing Authority may release this information, without responsibility for the further use or transmission of the evidence by the entity receiving it to: (1) HUD, as required by HUD; and (2) to the USCIS for purposes of verification of the Immigration status of each individual and not for any other purpose.

Penalties for misusing this Consent: HUD, the Housing Authority and any owner (or any employee of HUD, the Housing Authority or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected on the consent form is restricted to the purposes cited on the form. Any person who knowing or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or resident/program participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or resident/program participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD, the Housing Authority or the owner responsible for the unauthorized disclosure or improper use.

AUTORIDAD DE LA VIVIENDA

Client No:

FORMULARIO DE AUTORIZACIÓN PARA VERIFICAR EL ESTADO DE INMIGRACIÓN CON EL SERVICIO DE CIUDADANÍA E INMIGRACIÓN DE ESTADOS UNIDOS (USCIS, por sus siglas en inglés)

AUTORIZACIÓN: Le concedo permiso a la Autoridad de la Vivienda a que solicite información del Servicio de Ciudadanía e Inmigración de Estados Unidos (USCIS, por sus siglas en inglés) con el fin de verificar mi elegibilidad y nivel de beneficios dentro de los programas de viviendas subsidiadas de la Autoridad de Vivienda. Tengo entendido que la Autoridad de Vivienda no puede usar la información para demorar, negar o anular la asistencia de vivienda debido al estado de inmigración de uno de los miembros de la familia, salvo como está estipulado por los reglamentos del Departamento de Vivienda y Desarrollo Urbano (HUD). Además, tengo entendido que se me debe dar una oportunidad para impugnar la determinación con el USCIS o con la Autoridad de Vivienda, o ambas.

Firmas:

ADULTO(S): MAYORES DE 18 Años

Jefe de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Cónyuge (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha

MENORES DE EDAD: MENORES DE 18 Años

Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha

Quién debe firmar: Para ser elegible para la asistencia de vivienda, cada adulto o menor que no sea ciudadano y que esté solicitando o actualmente reciba asistencia de vivienda, debe estar legalmente en los Estados Unidos. Por favor lea cuidadosamente el formulario de autorización de verificación, fírmelo y devuélvalo como se indica. Por favor no dude en consultar a un abogado especializado en asuntos de inmigración u otro perito de inmigración de su elección.

Declaración de Ley de Confidencialidad: La información de este formulario la solicita la Autoridad de Vivienda para determinar la elegibilidad del solicitante o participante para la asistencia de vivienda. La Autoridad de Vivienda puede compartir esta información, sin responsabilidad del uso posterior o envío de evidencia por parte de la entidad que la reciba con: (1) HUD, como lo requiere HUD; y (2) el USCIS para fines de verificación del estado de inmigración de cada individuo y no para otros fines.

Penalidades por el uso inadecuado de esta autorización: HUD, la Autoridad de Vivienda y cualquier propietario (o cualquier empleado de HUD, de la Autoridad de Vivienda o del propietario) estará sujeto a penalidades por divulgaciones sin autorización o por usos inadecuados de la información, según el formulario de autorización.

El uso de la información contenida en este formulario de autorización está limitado a los fines estipulados en el mismo. Cualquier persona que a sabiendas y deliberadamente solicite, obtenga o divulgue cualquier dato usando falsos pretextos con respecto a un solicitante o residente/participante de programa, estará sujeto a un delito menor y será multado hasta $5000. Cualquier solicitante o residente/participante de programa que se vea afectado por la divulgación negligente de información, puede presentar una demanda por daños y solicitar otra compensación, según sea apropiado, en contra de HUD, la Autoridad de Vivienda o el propietario responsable por la divulgación sin autorización o el uso inadecuado de la misma.

Housing Authority of the City of Los Angeles

Authorization to Release Information

CLIENT #: _____

I authorize the Housing Authority of the City of Los Angeles (HACLA) to release any requested information, to provide copies of any documents contained in my file, and to discuss any topic relevant to my application for or participation in a HACLA assisted housing program with the following and their agents or employees:

☐ Legal Aid Foundation or Neighborhood Legal Services

Attorney's Name: _____

☐ My congressperson or local elected representative

Representative's name: _____

☐ Other (please name): _____

Client's Name: _____

Signature: _____ Date: _____

Releasing Information to the Media:

The HACLA does not release information to the media (television, radio, newspapers, etc.) except as authorized by its Community Relations Division. This form cannot be used to authorize release of any information to the media other than to a specific media ombudsperson indicated above.

La Autoridad de La Vivienda de la Ciudad de Los Ángeles

Permiso de Autorización para Relevar Información

CLIENT #: _____

Autorizó a la Autoridad de la Vivienda de la Ciudad de Los Ángeles (HACLA – por sus siglas en inglés) que revele cualquier información pedida, para proporcionar copias de cualquier documento que contenga mi expediente, y de discutir cualquier tema relacionado con mi solicitud para o participación en un programa de asistencia de vivienda de HACLA con los siguientes representantes o empleados:

☐ Fundación de Asistencia Legal o Servicio Legal comunitario

Nombre del Abogado: _____

☐ Mi congresista o representante electo local

Nombre del representante: _____

☐ Otro (nombre por favor):_____

Nombre del Cliente: _____

Firma: _____ Fecha: _____

Revelando información a los medios de comunicación:

La HACLA no revela información a los medios de comunicación (televisión, radio, periódico, etc.) excepto como se autorice por el Departamento de Relaciones Comunitarios. Esta forma no se puede usar para autorizar la revelación de cualquier información a los medios de comunicación excepto al mediador en asuntos de interés público de un medio especifico de comunicación anteriormente señalado.

Applicant ID: _____

AUTHORIZATION FOR RELEASE OF INFORMATION (Page 1 of 2)

INSTRUCTIONS: EACH MEMBER OF THE HOUSEHOLD WHO IS 18 YEARS OF AGE OR OLDER MUST SIGN ON THE FOLLOWING PAGE

The undersign(s) do hereby authorize any agency, office, group, organization, business firm, financial institution, public or private school, or governmental entity, to release to the Housing Authority, any information or materials which the Housing Authority deems necessary to complete and verify my application for participation and/or to maintain my continued assistance under the Section 8 Certificate Program, Housing Voucher Program, Low Income Housing Programs, or any other housing program that the Housing Authority may administer.

The information needed may include, but is not limited to: verification or inquiries regarding my identity, household members (including minors in my household), employment, income, financial accounts, assets, school records, allowances or preferences I have claimed, and residency.

The entities from which the Housing Authority may request information shall include, but are not limited to: financial institutions (42 U.S.C. Sec 3544); social service agencies; educational institutions; welfare agencies; Veteran's Administration; court clerks; utility companies; workmen's compensation payers; public and private retirement systems; law enforcement agencies; credit providers; postal service; and unemployment insurance agencies.

Records from financial institutions shall include all credit card account statements, loan account statements, mortgage account statements, loan applications, credit applications and any and all other account statements.

It is understood and agreed that this authorization or the information obtained with its use may be given to and used by the Housing Authority in the administration and enforcement of program rules and regulations and that the Housing Authority may in the course of its duties obtain such information from other Federal, State, or local agencies including State Employment Security Agencies; Department of Defense; Office of Personnel Management; the Social Security Administration; and welfare and food stamp agencies.

I understand and agree that a photocopy of this authorization may be used for the purposes stated above. This authorization for release of information expires fifteen months from the date signed.

(Signatures and family information required on following page)

Applicant ID: _____

AUTHORIZATION FOR RELEASE OF INFORMATION (Page 2 of 2)

(This consent form expires 15 months from the date signed)

Instructions: Provide information requested below for all household members.

Printed Name (Head of Household)		Social Security Number
Address	City	State Zip
Telephone Number		Date of Birth
Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending

INSTRUCTIONS: All members of the household 18 years of age and older must sign below.

Signature - Head of Household	Date
Signature - Other Adult	Date
Signature - Other Adult	Date
Signature - Other Adult	Date

Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD) and the Housing Agency/Authority (HA)

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

OMB CONTROL NUMBER: 2501-0014

exp. 07/31/2017

PHA requesting release of information; **(Cross out space if none)** (Full address, name of contact person, and date)	IHA requesting release of information: **(Cross out space if none)** (Full address, name of contact person, and date)

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

OMB Control # 2502-0581
Exp. (11/30/2015)

Optional and Supplemental Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

☐ Check this box if you choose not to provide the contact information.

Applicant Name:	
Mailing Address:	
Telephone No:	**Cell Phone No:**
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

Signature of Applicant **Date**

U.S. Department of Housing and Urban Development

Office of Public and Indian Housing

DEBTS OWED TO PUBLIC HOUSING AGENCIES AND TERMINATIONS

NOTICE TO APPLICANTS AND PARTICIPANTS OF THE FOLLOWING HUD RENTAL ASSISTANCE PROGRAMS:

- Public Housing (24 CFR 960)
- Section 8 Housing Choice Voucher, including the Disaster Housing Assistance Program (24 CFR 982)
- Section 8 Moderate Rehabilitation (24 CFR 882)
- Project-Based Voucher (24 CFR 983)

The U.S. Department of Housing and Urban Development maintains a national repository of debts owed to Public Housing Agencies (PHAs) or Section 8 landlords and adverse information of former participants who have voluntarily or involuntarily terminated participation in one of the above-listed HUD rental assistance programs. This information is maintained within HUD's Enterprise Income Verification (EIV) system, which is used by Public Housing Agencies (PHAs) and their management agents to verify employment and income information of program participants, as well as, to reduce administrative and rental assistance payment errors. The EIV system is designed to assist PHAs and HUD in ensuring that families are eligible to participate in HUD rental assistance programs and determining the correct amount of rental assistance a family is eligible for. All PHAs are required to use this system in accordance with HUD regulations at 24 CFR 5.233.

HUD requires PHAs, which administers the above-listed rental housing programs, to report certain information at the conclusion of your participation in a HUD rental assistance program. This notice provides you with information on what information the PHA is required to provide HUD, who will have access to this information, how this information is used and your rights. PHAs are required to provide this notice to all applicants and program participants and you are required to acknowledge receipt of this notice by signing page 2. Each adult household member must sign this form.

What information about you and your tenancy does HUD collect from the PHA?

The following information is collected about each member of your household (family composition): full name, date of birth, and Social Security Number.

The following adverse information is collected once your participation in the housing program has ended, whether you voluntarily or involuntarily move out of an assisted unit:

1. Amount of any balance you owe the PHA or Section 8 landlord (up to $500,000) and explanation for balance owed (i.e. unpaid rent, retroactive rent (due to unreported income and/ or change in family composition) or other charges such as damages, utility charges, etc.); and
2. Whether or not you have entered into a repayment agreement for the amount that you owe the PHA; and
3. Whether or not you have defaulted on a repayment agreement; and
4. Whether or not the PHA has obtained a judgment against you; and
5. Whether or not you have filed for bankruptcy; and
6. The negative reason(s) for your end of participation or any negative status (i.e., abandoned unit, fraud, lease violations, criminal activity, etc.) as of the end of participation date.

Who will have access to the information collected?
This information will be available to HUD employees, PHA employees, and contractors of HUD and PHAs.

How will this information be used?
PHAs will have access to this information during the time of application for rental assistance and reexamination of family income and composition for existing participants. PHAs will be able to access this information to determine a family's suitability for initial or continued rental assistance, and avoid providing limited Federal housing assistance to families who have previously been unable to comply with HUD program requirements. If the reported information is accurate, a PHA may terminate your current rental assistance and deny your future request for HUD rental assistance, subject to PHA policy.

How long is the debt owed and termination information maintained in EIV?
Debt owed and termination information will be maintained in EIV for a period of up to ten (10) years from the end of participation date.

What are my rights?
In accordance with the Federal Privacy Act of 1974, as amended (5 USC 552a) and HUD regulations pertaining to its implementation of the Federal Privacy Act of 1974 (24 CFR Part 16), you have the following rights:

1. To have access to your records maintained by HUD, subject to 24 CFR Part 16.
2. To have an administrative review of HUD's initial denial of your request to have access to your records maintained by HUD.
3. To have incorrect information in your record corrected upon written request.
4. To file an appeal request of an initial adverse determination on correction or amendment of record request within 30 calendar days after the issuance of the written denial.
5. To have your record disclosed to a third party upon receipt of your written and signed request.

What do I do if I dispute the debt or termination information reported about me?
If you disagree with the reported information, you should contact in writing the PHA who has reported this information about you. The PHA's name, address, and telephone numbers are listed on the Debts Owed and Termination Report. You have a right to request and obtain a copy of this report from the PHA. Inform the PHA why you dispute the information and provide any documentation that supports your dispute. HUD's record retention policies at 24 CFR Part 908 and 24 CFR Part 982 provide that the PHA may destroy your records three years from the date your participation in the program ends. To ensure the availability of your records, disputes of the original debt or termination information must be made within three years from the end of participation date; otherwise the debt and termination information will be presumed correct. Only the PHA who reported the adverse information about you can delete or correct your record.

Your filing of bankruptcy will not result in the removal of debt owed or termination information from HUD's EIV system. However, if you have included this debt in your bankruptcy filing and/or this debt has been discharged by the bankruptcy court, your record will be updated to include the bankruptcy indicator, when you provide the PHA with documentation of your bankruptcy status.

The PHA will notify you in writing of its action regarding your dispute within 30 days of receiving your written dispute. If the PHA determines that the disputed information is incorrect, the PHA will update or delete the record. If the PHA determines that the disputed information is correct, the PHA will provide an explanation as to why the information is correct.

This Notice was provided by the below-listed PHA:	**I hereby acknowledge that the PHA provided me with the *Debts Owed to PHAs & Termination N*otice:**
	Signature **Date**
	Printed Name

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

CalWORKS HOMELESSNESS CERTIFICATION

To: Los Angeles County DPSS Office

Date _____

Cal/Manager Code _____

Client No./Entity ID No. _____

Return to: HACLA 2600 Wilshire Blvd, 2nd Fl, Los Angeles, CA 90057

Attention _____ Phone _____

Please provide the information requested below. This information will only be used for official business between the Housing Authority of the City of Los Angeles (HACLA) and the Department of Public Social Services (DPSS) to determine eligibility for additional assistance through CalWORKS.

Name: _____ **SSN:** _____

Case name, if different: _____ **DOB:** _____

Address: _____

Check all statements that apply:

☐ I am currently a CalWORKS recipient.
☐ I currently reside in a shelter or transitional housing.
☐ I currently sleep in a public or private place not designed or ordinarily used for that purpose.
☐ I am currently in need of housing in a motel/hotel, shelter, or transitional housing.

Applicant Certification: I hereby certify that all the information above is true and correct to the best of my knowledge. With my signature, I also authorize the Housing Authority of the City of Los Angeles to release to the Department of Public Social Services in writing, by telephone or computer matching the requested information concerning my application. I understand that this authorization is valid for eighteen (18) months from the date below.

Signature _____ **Date** _____

DPSS STAMP HERE

Date _____

DPSS Employee Name _____

Employee signature _____

Telephone _____

WARNING: 18 U.S.C 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY - AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Blvd. 2nd Fl. - Los Angeles, California 90057 - (213) 252-2500
www.hacla.org *TTY (213) 252-2646*

CERTIFIED STATEMENT

Knowing the penalty for making a false statement under the United States Criminal code, I hereby certify that the following is a true statement.

My name is _____

My Social Security number is _____

I live at _____

Write **YES** or **NO** to each of the statements as they apply to you.

1. I am working at the present time. 1. _____
2. I have worked in the past 12 months. 2. _____
3. I am self-employed (including babysitting, laborer, sales). 3. _____
4. I attend high school, trade school or college. 4. _____
5. I receive welfare (TANF, Cal Works, CAPI, General Relief and/or Food Stamps) 5. _____
6. I receive unemployment or disability benefits. 6. _____
7. I receive contributions or child support. 7. _____
8. I receive SSI, Social Security, and/or Private Pension. 8. _____
9. I have a bank account. 9. _____
10. I receive income from assets (real estate, stocks, and bonds). 10. _____
11. I receive income from the Veterans Administration. 11. _____

Additional comments or information _____

_____

Signature:_____ Date:_____

Warning: Section 35(A) of the United States Criminal code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction.

Section 487i of the California Penal Code states that any person who defrauds a housing program of a public housing authority of more than four hundred dollars ($400) is guilty of grand theft.

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DECLARACION CERTIFICADA

Conociendo la pena por hacer declaraciones falsas de acuerdo al Código Penal de los Estados Unidos, por la presente certifico que lo siguiente es una declaración verdadera y completa:

Me llamo _____

Mi número de Segura Social es _____

Vivo en _____

Escriba **SI 0 NO** después de las siguientes afirmaciones dependiendo si son a no pertinentes a su situación.

1. Tengo empleo actualmente. 1. _____
2. He estado empleado los últimos doce (12) meses. 2. _____
3. Trabajo par mi cuenta (incluido cuidar niños, jornalero, ventas). 3. _____
4. Voy a la preparatoria (high school), a una escuela de oficios a la Universidad (college). 4. _____
5. Recibo asistencia social o ayuda del gobierno (TANF, Cal Works, CAPI, General Relief y/o Food Stamps). 5. _____
6. Recibo beneficios de desempleo o de discapacidad. 6. _____
7. Recibo contribuciones 0 manutención de menares (child support). 7. _____
8. Recibo beneficios del seguro de ingresos suplementarios (SSI), Segura Social y/o una _____ pensión de jubilación privada. 8. _____
9. Tengo una cuenta en el banco. 9. _____
10. Recibo ingresos de actives (bienes raíces, acciones, bonos). 10. _____
11. Recibo ingresos de la Administración de Veteranos. 11. _____

Comentarios a información adicional _____

Firma:_____ Fecha:_____

ADVERTENCIA: El Articulo 35A del Código Penal de los Estados Unidos establece que es un delito penal, punible con un máximo de diez (10) anos de encarcelamiento, una multa de $10,000.00 o ambas casas, hacer una declaración o representación falsa a algún departamento u oficina de los Estados Unidos en cualquier asunto dentro de su jurisdicción.

El articulo 487i del Código Penal del estado de California dice que toda persona que defraude mas de cuatrocientos dólares ($400) a un programa de una autoridad de vivienda es culpable de hurto mayor.

U.S. Department of Housing and Urban Development
Office of Inspector General

November 2004

Things You Should Know

Don't risk your chances for Federally assisted housing by providing false, incomplete, or inaccurate information on your application forms.

Purpose

This is to inform you that there is certain information you must provide when applying for assisted housing. There are penalties that apply if you knowingly omit information or give false information.

Penalties for Committing Fraud

The United States Department of Housing and Urban Development (HUD) places a high priority on preventing fraud. If your application or recertification forms contain false or incomplete information, you may be:

- Evicted from your apartment or house:
- Required to repay all overpaid rental assistance you received:
- Fined up to S 10,000:
- Imprisoned for up to 5 years; and/or
- Prohibited from receiving future assistance.

Your State and local governments may have other laws and penalties as well.

Asking Questions

When you meet with the person who is to fill out your application, you should know what is expected of you. If you do not understand something, ask for clarification. That person can answer your question or find out what the answer is.

Completing The Application

When you answer application questions, you must include the following information:

Income

- All sources of money you or any member of your household receive (wages. welfare payments, alimony, social security, pension, etc.):
- Any money you receive on behalf of your children (child support, social security for children, etc.);
- Income from assets (interest from a savings account, credit union, or certificate of deposit: dividends from stock, etc.);
- Earnings from second job or part time job;
- Any anticipated income (such as a bonus or pay raise you expect to receive)

Assets

- All bank accounts, savings bonds, certificates of deposit, stocks, real estate, etc., that are owned by you and any adult member of your family's household who will be living with you.

- Any business or asset you sold in the last 2 years for less than its full value, such as your home to your children.
- The names of all of the people (adults and children) who will actually be living with you, whether or not they are related to you.

Signing the Application

- Do not sign any form unless you have read it, understand it, and are sure everything is complete and accurate.
- When you sign the application and certification forms, you are claiming that they are complete to the best of your knowledge and belief. You are committing fraud if you sign a form knowing that it contains false or misleading information.
- Information you give on your application will be verified by your housing agency. In addition, HUD may do computer matches of the income you report with various Federal, State, or private agencies to verify that it is correct.

Recertifications

You must provide updated information at least once a year. Some programs require that you report any changes in income or family/household composition immediately. Be sure to ask when you must recertify. You must report on recertification forms:

- All income changes, such as increases of pay and/or benefits, change or loss of job and/or benefits, etc., for all household members.
- Any move in or out of a household member; and,
- All assets that you or your household members own and any assets that was sold in the last 2 years for less than its full value.

Beware of Fraud

You should be aware of the following fraud schemes:

- Do not pay any money to file an application;
- Do not pay any money to move up on the waiting list;
- Do not pay for anything not covered by your lease;
- Get a receipt for any money you pay; and,
- Get a written explanation if you are required to pay for anything other than rent (such as maintenance charges).

Reporting Abuse

If you are aware of anyone who has falsified an application, or if anyone tries to persuade you to make false statements, report them to the manager of your complex or your PHA. If that is not possible, then call the local HUD office or the HUD Office of Inspector General (OIG) Hotline at (800) 347-3735. You can also write to:
HUD-OIG HOTLINE, (GFI) 451 Seventh Street, S.W., Washington, DC. 20410.

Signature(s) ALL adults: _____ Date: _____

_____ Date: _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

NOTICE OF NONDISCRIMINATION BASED ON DISABILITY AND REASONABLE ACCOMMODATION POLICY

The Housing Authority of the City of Los Angeles (HACLA) strives to provide equal opportunity for all individuals to participate in and benefit from its programs in compliance with state and federal fair housing laws. An individual with a physical or mental disability may request a change, exception, or adjustment to a HACLA rule, policy, service, or modification to a dwelling unit or common space also known as a ***Reasonable Accommodation*** to obtain equal access to the HACLA programs.

A request can be submitted at any time. Request for services, such as sign language interpretation for a meeting, must be made orally or in writing at least five (5) business days in advance of the need.

A reasonable accommodation can only be granted if there is a ***verified*** disability-related need for the accommodation. HACLA may require verification as to the disability and/or the relationship to the accommodation requested if the disability and/or accommodation requested is not apparent or otherwise known to the HACLA. The HACLA will not inquire about diagnosis or other medical details. You are only required to disclose a disability to the HACLA if you request an accommodation or claim a deduction or eligibility preference for admission to a program based on disability.

Verifications may be provided by an individual who is in position to know of the disability and the need requested such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor.

A. Examples of Exceptions to Services, Policies or Procedures include, but are not limited to:

- Rescheduling an interview appointment and/or a non-office visit (e.g.: home visit)
- Providing sign language interpreters for meetings or interviews
- Using a text telephone (TTY) for telephone calls or e-mail with hearing or speech impaired persons
- Permitting a person with disabilities to have outside assistance to meet program requirements
- Meeting clients in wheelchair-accessible areas or providing space to accommodate a service animal

B. Examples of Modifications to Dwelling Units and Common Areas include, but are not limited to:

- Installing grab bars, handrails, wheelchair ramps or lever hardware for a mobility-impaired person
- Modifying units for hearing-impaired and vision-impaired persons (i.e., providing appropriate doorbells, etc.)

HACLA-owned units Residents of HACLA-owned units can request modifications to a unit or common area. The HACLA pays for most modifications to HACLA-owned units.

Section 8 Programs A tenant with a disability *must get the unit owner's permission* to modify a unit (preferably in writing) - *the owner may ask for verification of need.* Depending on the building the tenant or the landlord may have to pay for unit modifications - for additional information, go to www.hacla.org/504.

You may request an accommodation from the HACLA orally to your worker or in writing, preferably using HACLA's, "*Reasonable Accommodation Questionnaire*" form (S504-02). The form is available at our offices, on the HACLA website, or call (213) 252-1879 to request one be mailed to you. HACLA staff may assist in the completion of the form(s) upon request. Persons with speech or hearing impairments may use the TTY number or email address below or California Relay to contact our office. The HACLA responds to requests within 30 days of receipt of request. HACLA will contact the requestor if more information is needed. The HACLA Reasonable Accommodation policy and related forms are also available on the HACLA website www.hacla.org/504.

If you believe that you have experienced discrimination in a Housing Authority program due to a disability, complete and submit a *Reasonable Accommodation or Disability Discrimination Grievance* form (S504-08). Denial of a reasonable accommodation request does not necessarily constitute discrimination.

Accessibility (Section 504) Coordinator
Housing Authority of the City of Los Angeles – Planning Department
2600 Wilshire Boulevard, 3rd Floor, Los Angeles, CA 90057
Telephone: (213) 252-1879 TTY: (213) 252- 5313 E-mail: coordinator@hacla.org

Print

Clear Form

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
REASONABLE ACCOMMODATION QUESTIONNAIRE

Print form on Legal Size Paper (8 1/2 x 14)

A person with a disability(ies) may request a change, exception or adjustment to HACLA's rules, policies, practices, procedures or modifications to its housing units or common areas as a reasonable accommodation. Requesting an accommodation does not affect participation in the program. **This form is to be completed and returned to the HACLA as part of the application and annual review process but can be requested and submitted at any time as needed.**
Contact your HACLA worker if assistance is needed in completing this form.

Head of Household Name: _____ Reg # / Client # _____

Address: _____ Phone # _____

Other preferred contact information: _____

Please check the appropriate box, provide the information as necessary, sign the bottom, and submit to the HACLA.

1. Does anyone in your household need a reasonable accommodation?

   ☐ No - If **No**, complete number 3 below

   ☐ Yes - If **Yes**, complete numbers 1a, 1b, 1c, 2, and 3 below

1a. Print the name of the family member requiring the accommodation _____

1b. Describe the accommodation needed _____

_____

_____

1c. Is this request to rescind a negative action taken by HACLA because the family did not comply with program requirements and the reason for not complying was due to a household member's disability? ☐ No ☐ Yes

If **Yes**, how did the disability prevent compliance with the rules and requirements of the program? *(Include any applicable dates*) _____

_____

_____

_____

2. Person who can verify the disability and the disability-related need for the accommodation, such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor).

Name: _____

Agency (if applicable): _____

Address: _____

Phone number: (_____ Fax number: (_____

E-mail (if known): _____

3. Signature: I certify the above information is correct:

_____ _____
Signature of Head of Household or Cohead — Date

Please submit the completed form to the HACLA

For HACLA use only

Received by: _____ Date _____

Notes:

Cal/Manager Code _____
Unit No._____
Reg./Client No._____
Review Month _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

VERIFICATION OF DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS) ASSISTANCE

To: Los Angeles County Department of Social Services (DPSS)

Cal/Mgr Code: _____

Client No.: _____

Name: _____ SSN: _____

Case Name if Different: _____ Number in Assisted Household _____

Address: _____

Please provide the information requested below. I certify that this information will only be used for official Housing Authority business to determine the client's eligibility and rent. Please return this form to the Housing Authority (address below) in the enclosed self addressed envelope or fax to (___)_____. **Do not return the form to the client**. Thank you for your assistance.

_____	_____	(___)_____	_____	_____
Name HACLA employee	Title	Phone	Signature	Date

Return To:

Attn:

Client Certification: I hereby authorize DPSS to release the information requested below concerning my eligibility, the amount of benefits, and the reason for benefit reduction to the Housing Authority in writing, by telephone, or by computer matching. This authorization is valid for one year from the date below.

Signature: _____ Date: _____

TO BE COMPLETED BY DPSS EMPLOYEE (please do not use the check digit in the case number.)

A. DPSS Case #: | | | | | | | | -- | | | **B**. Aid Type _____

C. Date of most recent case opening: _____ **D**. Effective date of present grant: _____

E. Number of persons aided: _____ **F**. Number of persons in the home: _____

G. Maximum Allowable Grant: _____ **H**. Actual Grant: _____

I. Is the family receiving Food Stamps? **Yes** **No** - If "yes," what is the cash value? _____

J. Any special needs? **Yes** **No** - If "yes," what is the purpose_____ Amount: $ _____

K. REDUCTIONS IN BENEFITS:

1. Is there a current reduction in benefits due to fraud? **Yes** ◯ **No** ◯ When did it start? _____
   If "yes," what is the amount of the reduction? $ _____ When will it end? _____
   During what months/years did the fraud occur? _____
   During that period, what was the monthly amount the client actually received? $_____

2. Is there a current reduction in benefits because:
   - The family failed to participate in an economic self-sufficiency program? **Yes** ◯ **No** ◯
   - The family failed to comply with a work activities requirement? **Yes** ◯ **No** ◯

   If "yes" to either, what is the amount of the reduction? $_____ When did it start? _____
   When is the reduction (sanction) expected to end? _____

3. Is there a current reduction in benefits due to reasons other than fraud or non-compliance? **Yes** ◯ **No** ◯
   If "yes," what is the amount of the reduction? $ _____ When will it end? _____
   Please state the reason for the benefit reduction: _____

L. Additional income of the family (Wages, SSA/SSI, Child Support, Other):

Source	Amt	Source	Amt
_____	$_____	_____	$_____
_____	$_____	_____	$_____

M. If no longer assisted, what was the termination date: _____

N. Client address if different from above: _____

DPSS Employee Signature: _____ Date: _____

Please print name: _____ Phone: (___)_____

File #: _____ District: _____

DPSS STAMP HERE

Please sign, date, and return this form to the Housing Authority only. Do not take or mail this form to any other agency, entity, or persons (including the client whose information is requested).

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HACLA USE ONLY

Date stamp receipt or document date, name, and title if oral verification

RE-29 4/2005

Cal/Manager Code	Client #	Household Last Name	Unit #

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL DPSS INFORMATION

(This consent form expires 15 months from the date it is signed)

I understand that I have a right to the privacy of my personal information. I also understand that provisions of law protect my information and identity as an applicant or recipient of public assistance. I have been told that the Housing Authority of the City of Los Angeles ("Authority") wants to use my personal information to determine if I am eligible to receive housing services.

I understand that if I sign this form, the Los Angeles County Department of Public Social Services ("DPSS") will share the information they have about me and the minor children I am the legal guardian of, including whether I receive public assistance, the amount of any assistance, and any sanctions which may have been imposed against me. I understand that by signing this form, I am voluntarily authorizing DPSS, its agents and employees to share the information they have about me and the minor children I am the legal guardian of.

I acknowledge that before signing this form, I have carefully read and fully understand its terms. This authorization will expire 15 months from the date of my signing. I understand that my refusal to sign this form will not impact the services I currently receive or am eligible to receive through DPSS; however, refusal to sign may lead to termination of my housing assistance provided by the Housing Authority. I understand that I have the right to revoke this authorization at any time by saying so in writing.

I understand that the U.S. Department of Housing and Urban Development ("HUD") and Authority conduct computer matching programs to verify the information supplied on my application or recertification. I understand and agree that this authorization and the information obtained with its use will be used by HUD and/or Authority in the administration and enforcement of program rules and regulations.

I understand, agree, and consent that a photocopy of this authorization may be used for the purposes stated above.

First Name	Last Name	Date of Birth	SSN	Signature

(ALL ADULT HOUSEHOLD MEMBERS MUST SIGN THIS RELEASE FORM)

RE-DPSS

Clave de Cal/Administrador	# del Cliente	Apellido de la Familia	# de Unidad

AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ANGELES

AUTORIZACIÓN PARA REVELAR INFORMACIÓN CONFIDENCIAL DEL DPSS

(Este formulario de consentimiento caduca a los 15 meses a partir de la fecha en que se firma)

Entiendo que tengo derecho a la privacidad de mi información personal. También entiendo que disposiciones de la ley protegen mi información e identidad como solicitante o recipiente de asistencia pública. Se me ha dicho que la Autoridad de Vivienda de la Ciudad de Los Angeles ("Autoridad") quiere utilizar mi información personal para determinar si soy elegible para recibir servicios de vivienda.

Entiendo que si firmo este formulario, el Departamento de Servicios Sociales Públicos del Condado de Los Angeles ("DPSS") compartirá la información que tiene de mí y de los menores de quienes soy el(la) tutor(a) legal, incluyendo si recibo asistencia pública, la cantidad de cualquier subsidio, y cualesquier sanciones que se hayan impuesto en mi contra. Entiendo que por mi firma de este formulario, estoy autorizando voluntariamente al DPSS, sus agentes y empleados a compartir la información que tienen acerca de mí y de los menores de quienes soy el(la) tutor(a) legal.

Reconozco que antes de firmar este formulario, he leído con detenimiento y entiendo completamente sus términos. Esta autorización caducará a los 15 meses a partir de la fecha de mi firma. Entiendo que mi negativa de firmar este formulario no afectará los servicios que recibo actualmente o para los que soy elegible de recibir a través del DPSS; sin embargo, la negativa de firmar puede conllevar a la terminación de mi subsidio de vivienda proveído por la Autoridad de Vivienda. Entiendo que tengo el derecho de revocar esta autorización en cualquier momento diciéndolo así por escrito.

Entiendo que el Departamento de Vivienda y Desarrollo Urbano de EE.UU. ("HUD") y la Autoridad conducen programas de confirmación informática para verificar la información proporcionada en mi solicitud o una nueva certificación. Entiendo y acuerdo que esta autorización y la información obtenida con su utilización serán usadas por HUD y/o la Autoridad en la administración y cumplimiento de las reglas y reglamentos del programa.

Entiendo, acuerdo y doy mi consentimiento de que una fotocopia de esta autorización puede ser utilizada para los fines expresados anteriormente.

Primer Nombre	Apellido	Fecha de Nacimiento	SSN	Firma

(TODOS LOS ADULTOS DEL HOGAR DEBEN FIRMAR ESTE FORMULARIO DE REVELACIÓN)

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

HUD'S ENTERPRISE INCOME VERIFICATION (EIV) SYSTEM AND HOUSING ASSISTANCE

The Housing Authority uses HUD's EIV system to verify social security numbers for all participants; Social Security and SSI income, earnings from jobs, and unemployment insurance for all Housing Authority public housing residents and Section 8 participants.

What is EIV?

- EIV is a system from HUD that provides current Social Security data, employment, new hire data, and unemployment insurance income.

- All employers in the State of California report wages and other income to the Federal Government. The California Employment Development Department reports all unemployment benefits. The Social Security Administration records all benefits paid to families. All this information is now available to the housing authority to help us accurately verify income to provide the correct amount of assistance to families.

Whose information is in the EIV system?

- Current public housing residents and Section 8 participants.

How will this affect me?

- The Housing Authority will check the EIV system each time you have a review. The Housing Authority will also use EIV information for fraud investigations.

- If **all** members of your household accurately report all income received to the Housing Authority, it will not affect you. **IF THE EIV DATA SHOWS THAT YOU OR A MEMBER OF YOUR HOUSEHOLD FAILED TO REPORT ALL INCOME YOU CAN LOSE YOUR SECTION 8**.

- The Housing Authority will not rely only on the information received from the EIV system. The Housing Authority will require a third-party verification from the source of income if you disagree with information in the EIV system.

Why is the Housing Authority doing this?

- HUD developed EIV to prevent fraud and to insure that families are reporting income correctly. HUD wants to make sure that needy families get the right amount of assistance.

Will I have to do anything?

- Report all income of any kind completely and accurately. You still need to bring all family members' most recent income verifications (Social Security/SSI Statement, paycheck stubs, bank statements, etc.) to your reviews. Housing Authority staff will tell you if your help is needed to resolve any differences between what you report and what the EIV reports.

- If you do not understand something on the application or recertification forms, always ask.

AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ÁNGELES

EL SISTEMA DE VERIFICACIÓN DE INGRESOS (EIV) Y AYUDA DE VIVIENDA DEL HUD

La Autoridad de Vivienda usa el Sistema de Ingresos (EIV, por sus siglas en inglés) del Departamento de Vivienda y Desarrollo Urbano (HUD, por sus siglas en inglés) para verificar los ingresos por el seguro social, el salario y el seguro de desempleo de todos los residentes de la vivienda pública y los participantes de la Sección 8 de la Autoridad de Vivienda.

¿Qué es EIV?

- EIV es el sistema del HUD que proporciona datos vigentes del Seguro Social, del empleo, de empleados recién contratados y de información sobre ingresos por el seguro de desempleo.

- Todos los empleadores del estado de California informan al gobierno federal los salarios y otros ingresos de sus empleados; el Departamento del Desarrollo del Empleo de California informa de todos los beneficios de desempleo que otorga; y la Administración del Seguro Social informa de todas las cantidades que entrega a las familias. Toda la información anterior se encuentra a disposición de la Autoridad de Vivienda para ayudarle a verificar los ingresos con precisión y ofrecer a las familias una cantidad justa de ayuda.

¿Sobre quién tiene información el sistema de EIV?

- Residentes que actualmente viven en viviendas de la vivienda pública y participantes de la Sección 8.

¿De qué manera me va a afectar esto a mí?

- La Autoridad de Vivienda va a consultar el sistema EIV siempre que le haga una revisión. Además, va a usar la información del EIV en las investigaciones de fraude.

- Si **todos** los miembros de su familia informan con exactitud a la Autoridad de Vivienda todos los ingresos que reciben, esto no le va a afectar. **Si los datos del EIV muestran que usted o un miembro de su familia no reportaron todos los ingresos, puede perder su Sección 8.**

- La Autoridad de Vivienda no va a basarse solo en la información que reciba del sistema EIV. Si usted no está de acuerdo con la información del sistema EIV, la Autoridad de Vivienda va a requerir una verificación de una tercera persona que la fuente de ingresos envíe.

¿Por qué está la HACLA haciendo esto?

- El HUD ideo el EIV para evitar el fraude y para asegurar que las familias informen sus ingresos con exactitud.
  El HUD quiere asegurar que las personas necesitadas reciban la cantidad justa de ayuda.

¿Tengo que hacer algo?

- Informe todos sus ingresos de cualquier tipo con exactitud. Todavía tiene que llevar a las revisiones las verificaciones de ingresos más recientes (Seguro Social/Estado de cuenta del Seguro Social, talones de cheque, estados de cuenta de los bancos, etc.) de todos los miembros de la familia. La Autoridad de Vivienda le va a informar si necesita su ayuda para resolver alguna diferencia entre lo que informa usted y lo que el EIV indica.

- Si hay algo que no entienda en los formularios de solicitud o en los formularios de certificaciones posteriores, pida que se lo expliquen.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SECTION 8 SPECIAL PROGRAM OPERATIONS

SHELTER PLUS CARE PROGRAM- CHRONICALLY HOMELESS

APPLICATION COVERSHEET AND CHECKLIST

The following forms are required for every applicant under the **Shelter + Care Program**. In order for the Housing Authority to expedite the process of reviewing and approving your referrals, please fill in all the forms thoroughly. Place a check mark to the document included in this application packet and stack forms in the following order:

Application Coversheet and Checklist Transmittal form

- Applicant Referral Letter or Transmittal Form
- CES Unique ID Referral Form
- Disclosure of Information on Lead-Based Paint (HAPP RLA-12) PRA/SRA only
- Applicant Questionnaire (HAPP-13) Sign, date & complete all spaces- **All Adults**
- Shelter + Care Inter Office Clearance
- Certification of Residence (Special Programs.HM-1)
- Certification of Chronic Homelessness (Special Programs.CH-2)
- Certification of Disability (Special Programs.Dis-3)
- Statement of Family Responsibility (HUD 52578-B) PRA/SRA
- Family Obligations (HAPP-149)
- Statement of Family Responsibility (Supportive Services)
- Verification of Department of Public Social Services (DPSS) Assistance
- CalWORKS Homelessness Certification
- ANC-19 Yes/No
- Things You Should Know
- Re-46 Certified Statement
- S504-2 Reasonable Accommodation Questionnaire

Provide the following documents for ALL that apply for each family member

- **Employment**
  - **Most recent and consecutive check stubs**
- **AFDC/Cal Works and/or General Relief/CAPI**
  - **Current Notice of Action/Verification of Benefits**
- **Social Security/Supplemental Security Income**
  - **Current Award Letter**
- **Pension/Annuity**
  - **Current Award Letter**
- **Unemployment/State Disability Insurance**
  - **Current Award Letter**
  - **Most recent and consecutive check stubs**
- **Child Support**
  - **Payment History Chart**
  - **Most recent and consecutive check stubs**
- **Adoption/Foster Care/Kin-Gap**
  - **Assistance Payment Letter**
- **Self Employed/Own Business**
  - **All pages of most recent year Tax Returns**
  - **W'2s & 1099s**
- **Bank Accounts**
  - **Most recent bank statement for all accounts (All Pages)**
- **Life Insurance**
  - **All pages of each policy**

Identification Documents

- **Valid Government Issued Identification (All Adults 18 & over)**
- **Permanent Residence Card (If Applicable)**
- **Social Security Card (All House Hold Members)**
- **Birth Certificates (All Minors)**

Client Name: _____ S.S. No._____
Submitted by: _____ Date: _____
Agency: DMH / _____ Phone #: _____

Shelter + Care / CoC and CoC Bonus

REFERRAL TRANSMITTAL FORM

(This form must accompany every application submitted. Please retain a copy.)

TO: Housing Authority of the City of Los Angeles
SPA Department
2600 Wilshire Blvd, 2nd Floor
Los Angeles, CA 90057

FROM: DMH /
(SPONSORING AGENCY NAME ONLY)

SUBJECT: REFERRALS SUBMITTED FOR APPROVAL

DATE: _____

The following referral is being submitted for approval for the LA COC/Shelter + Care Program

HA Contract No. _____

HOUSING TYPE:

[ ] Tenant Based [ ] Sponsor Based [ ] Project Based [ ] Expansion Unit

BED SIZE **based on allocation**: (Circle One) **SRO 0 1 2 3**

Unit Name & Address (If Applicable):
_____
_____
_____

CLIENT'S NAME: _____

SSN: _____ SEX: _____ DOB: _____

REFERRED FROM: [ ] CES [ ] Other: _____

DMH / DHS approval: _____

Certification to be completed by the Referring Agency NPO or ICMS Provider

This Referral has been reviewed and approved by:

Agency Name: DMH / Federal Housing Subsidies Unit

Carl D. Davis
Name of Authorized Representative

(213) 480 - 3621
Telephone Number

_____
Signature

CaDavis@dmh.lacounty.gov
Email Address

CES REFERRAL FORM

This referral MUST be completed by your SPA's Coordinated Entry System (CES) Community Coordinator or Community Matcher.

CLIENT NAME: _____

CES/HMIS ID: _____ DOB: _____ SPA: _____

REFERRING AGENCY NAME: _____

AGENCY CONTACT: _____

AGENCY ADDRESS: _____

City / State / Zip: _____

AGENCY PHONE: _____

_____

AGENCY CONTACT SIGNATURE

_____

DATE

Please attach agency stamp or business card of Agency Contact completing this form in the box below:

Attach agency stamp or business card:

CES Community Coordinator and Matcher

SPA	Organization	Community Coordinator	Contact Info	Community Matcher	Contact Info
1	Valley Oasis	Diane Grooms	dvgrooms@avdvc.org	Andrea Stocker	astocker@avdvc.org
2	LA Family Housing	Christina Miller	cmiller@lafh.org	Nathaniel Vergrow	nvergow@lafh.org
3	Union Station Homeless Services	Sieglinde Von	svondeffner@unionstationhs.	Sieglinde Von Deffner	svondeffner@unionstationhs.org
4	LAMP, Inc.	Hazel Lopez	hazell@lampcommunity.org	Liz Sanford	matcher@thecenterinhollywood
5	St. Joseph Center	Lindsay Saunders	lsaunders@stjosephctr.org	Kela Caldwell	kcaldwell@stjosephctr.org
6	Special Services for Groups	Takita Salisberry	tsalisberry@hopics.org	Nicole Bay	nbay@hopics.org
7	PATH (People Assisting The Homeless)	Meredith Berkson	meredithb@ePath.org	Jonathan Sanabria	jonathans@ePath.org
8	Harbor Interfaith Services, Inc.	Shari Weaver	sweaver@harborinterfaith.or	Alex Devin	adevin@harborinterfaith.org

Updated 12/06/16

SPECIAL PROGRAMS
Shelter + Care
Applicant Questionnaire

Applicant's Name: _____

Adult's Name: _____ **Date of Birth:** _____
California ID Number: _____ **Social Security Number:** _____

WARNING: Falsification or concealment of a material fact or submission of false, or fraudulent statements to any Department or Agency of the United States Government may result in a fine of not more than $10,000 or imprisonment for not more than five (5) years, or both. (18 U.S.C. 1001) **The Housing Authority has the right to request from other agencies and information from HUD and public housing agencies to decide whether you are eligible for assistance.**

1. Please list all the States (in the U.S.A.) where you have lived since you were 18 years of age:
States:

_____

2. During the last 5 years have you been on any Section 8 program? Yes ☐ No ☐

If yes, please provide the following information about the housing authority:
Name of the housing authority: _____
State: _____ City: _____ Phone: _____
When did you leave the Section 8 program? Month: _____ Year _____

_____

3. During the last 5 years have you lived in any other federally assisted housing? Yes ☐ No ☐

If yes, please provide the following information:
Name of the housing authority or owner: _____
State: _____ City: _____ Phone: _____
When did you leave assisted housing? Month: _____ Year: _____

_____

4. Were you removed from Section 8 or evicted from Section 8 or any other federally assisted housing within the last 5 years? Yes ☐ No ☐

If yes, when? _____
Why? _____

_____

5. Have you ever been told that you owe money to a housing authority or housing agency? Yes ☐ No ☐

If yes, what housing authority or agency? _____

_____

6. Have you ever been told you committed fraud while you were in Section 8 or any other assisted housing program? Yes ☐ No ☐

If yes, when: Month: _____ Year: _____ Where? _____

I certify that all the above answers are correct. I understand that the Housing Authority has the right to request information from law enforcement and housing agencies to determine my eligibility.
Signature: _____ Date: _____

Special Programs
Shelter + Care Clearance (HACLA use Only)

Date Submitted: _____ **Initial Interview Date:**_____

TO: HACLA _____

FROM: DMH / _____

Authorized Representative Signature:_____

Adult Signature: _____**Date**: _____

Applicant ● Live-In Aide O Adding to HH O _____

CLEARANCE REVIEW :

Did the person receive housing assistance in the past? Yes O No O

If yes,
where?_____From_____To_____.

Does the person have a record of any prior terminations from assisted housing for program violations? _____Yes _____No

If yes, Reason
_____

Termination Date_____ Eviction Date: _____

(Refer to Terminations & Denials Matrix) (if applicable)

Eligibility Date_____ Denied? _____Y _____N

CCSS8 Cleanrance Completed ?	**YES** O	**NO** O
Elite Clearance Completed?	**YES** O	**NO** O
Debts Owed Clearance Completed ?	**YES** O	**NO** O

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SPECIAL PROGRAMS
CERTIFICATION OF HOMELESSNESS/RESIDENCE

To: _____ Date: _____

_____

_____

Dear: _____

_____ ("Applicant") has applied to receive rent payment assistance provided through the Housing Authority of the City of Los Angeles. To quality for assistance, the Applicant must be homeless as defined by Federal Program Regulations.

This information will be used only for the purpose of determining the homeless status for the above-named applicant.

Sincerely,

_____ I hereby authorize the release of the requested information
(Signature)

_____ _____
(Title) (Signature of Applicant)

CERTIFICATION

I certify that: _____stayed at _____
(name of applicant) (name of facility)

for the period _____
(beginning and ending dates of stay)

Before coming to this facility, the applicant resided at _____

Signature: _____ Date: _____
(Signature of Facility staff person)

Title: _____ Telephone: _____

Facility: _____
(Name and Address of Facility)

Type of Facility:

☐ Emergency Shelter

☐ Transitional Housing

☐ HUD-defined Safe Haven

☐ Institution (jail, hospital, etc.)

☐ Other (specify) _____

SUMMARY

How did applicant become homeless? _____

_____

_____

_____

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
Special Programs
CERTIFICATION OF CHRONIC HOMELESSNESS

I certify that _____is a Chronically Homeless Individual/Family.
(Name of Applicant)

☐ Is a homeless individual (a single person who is alone) or part of a homeless family.

AND

☐ Has a disabling condition, defined as a diagnosable substance use disorder, serious mental illness, or AIDS and related diseases, including the co-occurrence of two or more of these conditions, which limits an individual's ability to work or perform one or more activities of daily living. (Attach Form HM/PBV-3)

AND

Is <u>currently</u> residing in:

☐ A place not designed for a regular sleeping accommodation for human beings, such as cars, parks, sidewalks, abandoned buildings, etc. (*Attach either: (1) written verification from an outreach worker or organization that has assisted the applicant and knows where the applicant resides); or (2) a written statement about the applicant's living place signed by the applicant);* ***or***

☐ A supervised publicly or privately owned emergency shelter designated to provide temporary living accommodations (Attach Form HM/PBV-1) **or**

☐ A HUD-defined Safe Haven (Attach Form HM/PBV-1) ***or***

AND

☐ Has been continuously homeless for one (1) year (*Attach verification as described above documenting at least one year living in a place not designed for regular sleeping accommodation, emergency shelter or Safe Haven*), **or**

☐ Has had at least four (4) episodes of homelessness in the past three (3) years. Each episode must be a separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter.

Signed: _____ Date: _____

Title: _____

Organization or Agency Name: DMH / _____

Address: _____

Telephone Number: _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
Homeless, Project Based Voucher Programs
CERTIFICATION OF CHRONIC HOMELESSNESS

Definition of Chronic Homelessness

Chronically homeless.

1) An individual who:

   (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; **and**

   (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; **and**

   (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; **or**

3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

SUMMARY: EPISODES OF HOMELESSNESS

NAME SHELTER/ADDRESS	ENTRY DATE	EXIT DATE

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
Special Programs
DISABILITY CERTIFICATION

Date: _____

Dear Physician/Qualified Health Personnel:

_____ has claimed eligibility for a federally funded housing program due to a disabling chronic condition. The claim must be certified by a licensed physician or qualified health professional.

For the purpose of this program, a disabled person is an individual with a physical, developmental or mental impairment that substantially limits one or more major life activities. Such impairments include, but are not limited to, such diseases and conditions as serious mental illness, orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

This disability must be expected to be of a long-continued and indefinite duration, substantially impede independent living, and is of such a nature that daily functioning and the disability could improve under more suitable housing conditions. Please provide the information requested below.

By: _____ I authorize release of the information below:
Agency Employee

_____
Signature of Applicant

MEDICAL CERTIFICATION

In my opinion, as a licensed physician/qualified health professional trained to evaluate such conditions, _____ **does not** have a disability as defined above.
Applicant's Name

In my opinion, as a licensed physician/qualified health professional trained to evaluate such conditions, _____ **does** have a disability as defined above.
Applicant's Name

Specifically, this disability is as follows:

_____

_____

Additional information concerning this disability:
This disability:

Is expected to be of long-continued and indefinite duration. ☐ Yes ☐ No

Substantially impairs his/her ability to live independently. ☐ Yes ☐ No

Is of such nature that daily functioning and the disability could improve under more suitable housing conditions. ☐ Yes ☐ No

This disability is:
☐ Chronic Physical Illness or Disability
☐ Serious Mental Illness
☐ Developmental Disability
☐ AIDS or HIV Related Diseases
☐ Diagnosable Substance Abuse Disorder
☐ Co-occurrence of Two or More of these Conditions

Signature: _____ **Print Name:** _____

Professional Title: _____ **Telephone:** _____

License Number: _____ **Date:** _____

Name of Medical Group (stamp preferred): _____

Address: _____

Organization Stamp:

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SECTION 8 ASSISTED HOUSING PROGRAM

SECTION 8 FAMILY OBLIGATIONS

When your unit is approved and the Housing Assistance Payments (HAP) contract is signed, your family must follow the rules listed below.

A. THE FAMILY MUST:

1. Provide CORRECT AND ACCURATE INFORMATION, including proof of CITIZENSHIP or eligible IMMIGRATION status, and records about your INCOME and the income of all family members living with you. You must report all income such as wages, unemployment benefits, child support, Social Security, SSI, pensions and all ASSETS such as bank accounts, stocks, bonds, property ownership, whether or not you have income from them. (Live-in aides are exempt from providing information regarding income)

2. Provide any INFORMATION that the Housing Authority or HUD tells you is needed for any reexamination of family income and composition. You and all adult family members must sign forms that allow us to verify income, asset and other information required by the Housing Authority. (Live-in aides are exempt from providing income information.)

3. Provide and verify SOCIAL SECURITY NUMBERS for all members of your family including live-in aide. This requirement does not apply to individuals who do not contend eligible immigration status.

4. Provide TRUE and COMPLETE information.

5. PAY gas, electric, water or any other utility bill for which you are responsible. PROVIDE and keep in repair any appliances such as a stove or refrigerator which the owner does not provide. REPAIR or pay for damage to the unit caused by any household member or guest. Pay your portion of the rent on time.

6. Allow the Housing Authority to INSPECT your unit at reasonable times after reasonable notice. We will inspect your unit at least once a year.

7. NOTIFY the Housing Authority and the owner IN WRITING before moving out of the unit, or ending the lease. You must get a new voucher before you can move with Section 8. You must give at least 30 days WRITTEN NOTICE if you plan to move from your unit.

8. Immediately give the Housing Authority a copy of any EVICTION NOTICE.

9. Use the section 8 unit as a place to live and ALLOW ONLY THE PEOPLE AUTHORIZED BY THE HOUSING AUTHORITY TO LIVE THERE. The unit must be a family's only place of living.

10. Immediately TELL the Housing Authority of the birth, adoption or court-awarded custody of a child. You must ask for and get WRITTEN APPROVAL before any other person (including family members, foster children or live-in aides) can live with you.

11. Immediately NOTIFY the Housing Authority IN WRITING if someone moves out or no longer lives in the unit.

12. Give the Housing Authority any information needed to prove that you or other family members are living in the unit or have moved out of the unit. (You must NOTIFY the Housing Authority of any time that you are away from the unit or expect to be away for more than thirty days.)

B. THE FAMILY MUST NOT:

1. COMMIT any serious or repeated VIOLATION OF THE LEASE.

2. Use your unit mainly as a place of business rather than as a place to live.

3. SIGN OVER the lease to someone else or GIVE the unit to someone else.

4. SUBLEASE or LEASE or charge someone else rent for the unit or a part of the unit.

5. BE AN OWNER of the unit you are living in (unless it is a mobile home) or have any interest in the unit.

6. Commit any FRAUD, bribery or any other corrupt or criminal act in connection with the program. Section 487i of the California Penal Code states that any person who defrauds a housing program of a public housing authority of more than four hundred dollars ($400) is guilty of grand theft.

CONTINUED ON BACK

All members of your family 18 years of age or older must sign this form.

_____	_____	_____
Signature	Signature	Signature
_____	_____	_____
Date	Date	Date

THE FAMILY MUST NOT (continued):

7. GIVE THE LANDLORD any secret or “under-the-table” money or pay more rent than the Housing Authority allows. If a landlord asks you to pay extra rent, notify your Section 8 Advisor at once.

8. USE DRUGS or take part in other DRUG-RELATED CRIMINAL ACTIVITY or in VIOLENT CRIMINAL ACTIVITY. The family must not participate in any other criminal activity that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing in the area near your unit. This applies to your entire household, whether or not you personally take part in the activity or even know about it.

9. ABUSE ALCOHOL in a way that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing near your unit.

10. RECEIVE ANY OTHER HOUSING ASSISTANCE (SUBSIDY) either to live in YOUR UNIT or to LIVE ELSEWHERE while you have Section 8 with us.

GROUNDS FOR DENIAL OR TERMINATION OF ASSISTANCE

The Housing Authority may deny or take away your Section 8 for any of the following:

1. If you and the members of your household do not follow the family obligations listed above.

2. If as an applicant you or any member of your household is required to have a criminal history record check, but does not sign the consent form or refuses to provide fingerprints if needed.

3. If you or any member of your household must register as a sex offender in any State.

4. If you or any member of your household ever produced or manufactured methamphetamine on the premises of federally assisted housing.

5. If you or any member of your household currently illegally uses drugs, or has a pattern of illegal use that may threaten the health, safety or right to peaceful enjoyment of the premises by other residents, or if you are evicted or convicted for drug related criminal activity.

6. If you or any member of your household abuses alcohol or has a pattern of abuse that threatens the health, safety or right to peaceful enjoyment of the premises by other residents, or if you are evicted for reasons related to alcohol abuse.

7. If you or any member of your household was evicted or removed for good reason from any of our assisted housing programs (including Section 8) within 5 years of your application interview.

8. If you or any member of your household commits fraud, bribery or any other corrupt or criminal act in connection with any federal housing program or has done such things within 10 years of your application interview.

9. If you or any household member owes rent or other amounts to any housing authority in connection with Section 8 or public housing assistance or has not repaid a housing authority for money paid to an owner under a Housing Assistance Payments Contract for rent, damages to the unit or other amounts owed under the lease.

10. If your family breaks a repayment agreement with this or any other housing authority to pay amounts you owe to the housing authority.

11. If you or any member of your household is abusive or violent or makes threats against any Housing Authority employee.

12. If you are in the Family Self Sufficiency (FSS) Program and, for no good reason, you do not follow the rules of your FSS contract.

13. If you are in the Welfare to Work Program and willfully and continually fail to meet your responsibilities under that program.

14. If you or any member of your family does not immediately give the Housing Authority a copy of any letter or notice from HUD that gives information about the amount of income you receive or about verifying family income.

15. If you do not move to another unit when the Housing Authority tells you that your family is too large for the Section 8 unit you are living in (or that your family is too small for its unit in the HOPWA and Shelter Plus Care programs).

16. If you do not accept an offer of assistance with conditions (that provides assistance to some family members but forbids others to live in the unit), or if any adult member of your family does not sign the statement of assistance with conditions, or if you violate the conditions.

AUTORIDAD DE LA VIVIENDA DE LA CIUDAD DE LOS ANGELES
PROGRAMA DE ASISTENCIA DE VIVIENDA DE SECCION 8

OBLIGACIONES DE LA FAMILIA EN SECCION 8

Cuando su unidad es aprobada y el contrato de asistencia de vivienda (HAP, por sus siglas en inglés) es firmado, su familia debe de seguir las regulaciones enlistadas a continuación.

A. LA FAMILIA DEBE:

1. Proveer INFORMACION CORRECTA Y PRECISA, incluyendo prueba de CIUDADANIA o de un estado INMIGRATORIO elegible, y datos acerca de su INGRESO y de los ingresos de todos los miembros de su familia que viven con usted. Usted debe reportar todos los ingresos como por ejemplo salarios, beneficio por desempleo, Seguro Social, pensiones y todos los BIENES como cuentas de banco, acciones, bonos, títulos de propiedades, ya sea o no que usted obtenga ingresos de ellos. (Los prestadores de servicios auxiliares a domicilio están exentos de proporcionar información relacionada con su ingreso)

2. Proveer cualquier INFORMACION que la Autoridad de la Vivienda o el Departamento de Vivienda y Desarrollo Urbano (HUD por sus siglas en inglés) le diga que se necesita para una reexaminación de los ingresos y la composición familiar. Usted y todos los miembros adultos de su familia deben firmar formas que nos permitan verificar los ingresos, bienes y otra información requerida por la Autoridad de la Vivienda. (Los prestadores de servicios auxiliares a domicilio están exentos de proporcionar información relacionada con su ingreso.)

3. Proveer y verificar NUMEROS DE SEGURO SOCIAL para todos los miembros de su familia incluyendo al prestador de servicios auxiliares. Este requerimiento no es necesario si decide no declarar su estado inmigratorio.

4. Proveer información COMPLETA y VERDADERA.

5. PAGAR las cuentas de gas, electricidad, agua o cualquier otro recibo por servicios públicos por los cuales usted es responsable. PROVEER y mantener en buenas condiciones cualquier electrodoméstico tal como estufa o refrigerador el cual no ha sido proveído por el propietario. REPARAR o pagar por los daños a la unidad ocasionados por cualquier miembro del hogar o invitado. Pagar su porción del alquiler a tiempo.

6. Permitir a la Autoridad de la Vivienda INSPECCIONAR su unidad en un horario razonable después de notificaciones razonables. Inspeccionaremos su unidad por lo menos una vez al año.

7. NOTIFICAR a la Autoridad de la Vivienda y al propietario POR ESCRITO antes de que se mude de la unidad, o cancele el contrato de alquiler. Usted debe obtener un vale nuevo antes de que se pueda mudar con Sección 8. Usted debe de dar un AVISO POR ESCRITO con 30 días de anticipación si usted tiene planes de mudarse de su unidad.

8. Proporcionar inmediatamente a la Autoridad de la Vivienda copia de cualquier AVISO DE DESALOJO.

9. Usar la unidad de Sección 8 como un lugar de residencia y SOLO PERMITIR RESIDIR EN LA VIVIENDA A LAS PERSONAS AUTORIZADAS POR LA AUTORIDAD DE LA VIVIENDA. La unidad debe ser el único lugar de residencia de la familia.

10. Inmediatamente NOTIFIQUE a la Autoridad de la Vivienda del nacimiento, adopción o custodia de un menor otorgada por una corte. Usted debe pedir y recibir una APROBACION POR ESCRITO antes de que cualquier persona (incluyendo familiares, o niños de crianza temporal o prestador auxiliar de servicio que vivan en casa) pueda residir con usted.

11. Inmediatamente NOTIFIQUE a la Autoridad de la Vivienda POR ESCRITO si alguien se muda o ya no reside en la unidad.

12. Proporcionar a la Autoridad de la Vivienda cualquier información necesaria para probar que usted o cualquier otro miembro de su familia están residiendo en la unidad o se han mudado de ella. (Usted debe NOTIFICAR a la Autoridad de la Vivienda sobre cualquier período de tiempo que usted se encuentre fuera o que planee estar ausente de su unidad por más de treinta días.)

B. LA FAMILIA NO DEBE:

1. COMETER ninguna VIOLACION DEL CONTRATO DE ALQUILER que sea seria o repetida.

2. Usar su unidad principalmente como un lugar negocio en vez de residencia.

3. FIRMAR PARA ALGUIEN MAS el contrato de alquiler o DARLE la unidad a alguien más.

4. SUBARRENDAR o ARRENDAR o cobrar a alguien alquiler por la unidad o por una porción de la unidad.

5. SER EL PROPIETARIO de la unidad en que usted reside (a menos que sea una casa movible) o que tenga algún provecho en la unidad.

6. Cometer cualquier tipo de FRAUDE, soborno o cualquier otro acto corrupto o criminal en relación con el programa. El artículo 487i del Código Penal del Estado de California establece que toda persona que defraude más de cuatrocientos dólares ($400.00) a un programa de una Autoridad de Vivienda es culpable de robo.

CONTINUA AL REVERSO

Todos los miembros de su familia que son de 18 años de edad o mayores deben firmar este formulario.

_____	_____	_____
Firma	Firma	Firma
_____	_____	_____
Fecha	Fecha	Fecha

LA FAMILIA NO DEBE (continuación):

7. DARLE AL PROPIETARIO cualquier dinero secreto o “por debajo de la mesa” o pagar mas alquiler que el que la Autoridad de la Vivienda le permite. Si un propietario le pide que usted pague extra alquiler notifique a su consejero de la Sección 8 inmediatamente.

8. USAR DROGAS o tomar parte en otra ACTIVIDAD CRIMINAL RELACIONADA CON DROGAS o en una ACTIVIDAD CRIMINAL VIOLENTA. La familia no debe participar en ninguna otra actividad criminal que atente con la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad. Esto aplica a todo su grupo familiar ya sea o no que usted tome parte de las actividades o que tenga conocimiento de ellas.

9. ABUSO DE ALCOHOL de una manera que atente contra la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad.

10. RECIBIR CUALQUIER OTRA ASISTENCIA A LA VIVIENDA (SUBSIDIO) ya sea para vivir en SU UNIDAD o para VIVIR EN ALGUN OTRO LUGAR mientras usted tiene Sección 8 con nosotros.

MOTIVOS PARA NEGACION O CANCELACION DE LA ASISTENCIA

La Autoridad de la Vivienda puede negar o quitarle su Sección 8 por cualquiera de las siguientes razones:

1. Si usted y los miembros de su grupo familiar no siguen las obligaciones familiares enlistadas anteriormente.

2. Si como solicitante a usted o a cualquier miembro de su grupo familiar se le requiere verificar el historial criminal, pero no firma los formularios de consentimiento o se rehúsa a proveer las huellas digitales si es necesario.

3. Si usted o cualquier miembro de su grupo familiar está registrado como un agresor sexual en cualquier estado de los Estados Unidos.

4. Si usted o cualquier miembro de su grupo familiar han producido o manufacturado metanfetamina en las instalaciones de vivienda que reciben asistencia federal.

5. Si usted o cualquier miembro de su grupo familiar se encuentran usando ilegalmente drogas o tienen un habito del uso ilegal que pueda atentar con la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad, o si usted ha sido desalojado o condenado por actividades criminales relacionadas con drogas.

6. Si usted o cualquier miembro de su grupo familiar abusa el alcohol o tiene el hábito de abusarlo y que pueda atentar con la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad, o si usted ha sido desalojado o condenado por actividades criminales relacionadas con el abuso del alcohol.

7. Si usted o cualquier miembro de su grupo familiar ha sido desalojado o retirado con buena razón de cualquiera de nuestros programas de asistencia a la vivienda (incluyendo Sección 8) durante los últimos 5 años de su entrevista como solicitante.

8. Si usted o cualquier miembro de su grupo familiar comete fraude, soborno o cualquier otro acto corrupto o criminal en conexión con cualquier programa de vivienda federal o ha cometido dichas actividades durante los últimos 10 años de su entrevista como solicitante.

9. Si usted o cualquier miembro de su grupo familiar debe alquiler u otra cantidad a cualquiera Autoridad de la Vivienda en conexión con Sección 8 o asistencia de vivienda pública o no ha pagado a alguna Autoridad de la Vivienda por dinero pagado a algún propietario bajo un contrato de Pagos de Asistencia de Vivienda por alquiler, daños a la unidad u otros adeudos relacionados con el contrato de alquiler.

10. Si su familia no cumple con un acuerdo de reembolso con esta o cualquier otra autoridad de la vivienda de pagar las cantidades que debe a la autoridad de la vivienda.

11. Si usted o cualquier miembro de su grupo familiar es abusivo o violento o hace amenazas en contra de cualquier empleado de la Autoridad de la Vivienda.

12. Si usted participa en el Programa de Autosuficiencia Familiar (FSS por sus siglas en inglés) y sin tener una buena razón, usted no sigue las regulaciones de su contrato de FSS.

13. Si usted participa en el Programa de Asistencia Pública para Trabajar (Welfare to Work, por su nombre en inglés) y premeditadamente y constantemente falla en cumplir con sus responsabilidades bajo este programa.

14. Si usted o cualquier miembro de su grupo familiar no entrega inmediatamente a la Autoridad de la Vivienda una copia de cualquier carta o notificación de HUD (Departamento Federal de Vivienda y Desarrollo Urbano) que de información acerca de la cantidad de ingreso que usted recibe o verificación acerca de los ingresos familiares.

15. Si usted no se muda a otra unidad cuando la Autoridad de la Vivienda le dice que su familia es muy grande para la unidad de Sección 8 donde usted está viviendo (o que su familia es muy pequeña para esa unidad en los programas de HOPWA (Oportunidades de Vivienda Para Personas con SIDA) y Shelter Plus Care (Programa de Alojamiento y Cuidado).

16. Si usted no acepta una oferta de asistencia con condiciones (que proporciona asistencia a algunos miembros de la familia pero prohíbe a otros que vivan en la unidad) o si algún otro adulto de la familia no firma la declaración de asistencia con condiciones, o si usted quebranta las condiciones.

Housing Authority of the City of Los Angeles
Certification of No Conflict of Interest

a. **A covered person may not have any direct or indirect interest in the HAP contract or in any benefits or payments under the contract (including the interest of an immediate family member of such covered individual) while such person is a covered individual or during one year thereafter.**

b. "Covered person" means a person or entity who is a member of any of the following classes:

(1) An employee, agent, consultant, officer, or elected or appointed official of the recipient or its subrecipients;

(2) A person who exercises or has exercised any functions or responsibilities with respect to activities assisted under the Shelter Plus Care or Continuum of Care Rental Assistance Program;

(3) A person who is in a position to participate in a decision-making process or gain inside information with regard to activities assisted under the Shelter Plus Care or Continuum of Care Rental Assistance Program; or

(4) A person who may obtain a financial interest or benefit from an assisted activity, have a financial interest in any contract, subcontract, or agreement with respect to an assisted activity, or have a financial interest in the proceeds derived from an assisted activity, either for him or herself or for those with whom he or she has immediate family or business ties, during his or her tenure or during the one-year period following his or her tenure.

d. The sponsor agency certifies and is responsible for assuring that no person or entity has or will have a prohibited interest, at execution of the HAP contract, or at any time during the HAP contract term.

e. If a prohibited interest occurs, the owner shall promptly and fully disclose such interest to the HACLA and HUD.

f. The conflict of interest prohibition under this section may be waived by the HUD field office for good cause.

SPONSOR CERTIFICATION

I/we certify, by my/our signature below, that in accordance with the above description I am/we are not a "covered person" as described above AND that I am/we are NOT an employee of the Housing Authority of the City of Los Angeles.

Sponsor's Signature_____ Date ____/____/____

Sponsor's Signature_____ Date ____/____/____

Sponsor's Signature_____ Date ____/____/____

If unable to certify, please provide your name and explain why:

_____

_____

FAMILY CERTIFICATION

I/we certify, by my/our signature below, that I am/we are not related to the Sponsor Agency.

Head of Household's Signature_____Date ____/____/____

Co-head's Signature_____ Date ____/____/____

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

Special Programs

Shelter Plus Care– Tenant, Sponsor or Project-Based Program

Statement of Family Responsibility (Supportive Services)

The Housing Authority of the City of Los Angeles has certified that the family headed by:

_____

is eligible to participate in the Shelter Plus Care Tenant, Sponsor or Project-Based Certificate Program

Under this program the Housing Authority makes Housing Assistance Payments on behalf of the participants toward their rent to owners of decent, safe, and sanitary housing units.

In addition to the requirements stated in the form titled **"Section 8 Family Obligations,"** & Statement Of Family Responsibility S8 Project-Based Assistance Rental Program, participants in the Shelter Plus Care Program are required to take part in the supportive services required by the following agency:

DMH /

_____

Failure of the participant to abide by the Section 8 Family Obligation or to take part in the supportive services required by the above agency will be a basis for termination of rental assistance under the Shelter Plus Care Program.

The above agency is required to notify the Housing Authority of your failure to participate in the supportive services provided by the above agency under the Shelter Plus Care Program.

_____ _____

Participant's Signature Date

_____ _____

Agency Representative Signature Date
Print Name and Title

CC: Agency/ Applicant

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY – AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Blvd, 4th floor – Los Angeles, California 90057 (213)252-2500
www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Manager Code _____
Client No. _____

My name is JOHN DOE

I live at Homeless on the streets on the corner of 1st St. and Main St. in Los Angeles, CA 99999

-OR- address of current residence

Warning: Title 18, Section 1001 of the United States code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Making false statements is a felony under California State Law (penal code sections: 115, 118, 487, 532) and may result in criminal charges including perjury, grand theft, filing false documents with a public office, and obtaining money under false pretenses.
Section 35(A) of the United States Criminal code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction. The information given above was requested by the HOUSING AUTHORITY OF THE CITY OF ANGELES in its capacity as a City, State, and Federal Agency.

Knowing the penalty for making a false statement under the United States Code, I hereby certify that the following is a true, correct, and complete statement.

On this form, please have the applicant describe the following in his/her own words and writing:

1) if your case manager is unable to certify your homelessness on the street, you must self-certify the timeline and locations when you lived on the street, if applicable

2) explain how you became homeless

3) explain the reason that the address on your CA ID/DL is different from your current residence

4) explain the reason that the address on your Income Verification Letter is different from your current residence

5) explain the reason that the address on your Bank Statement is different from your current residence

This statement was completed, signed and dated knowingly, freely, and voluntarily, without threats or duress from anyone to obtain my statement.

Signature _____ Date _____

Witnessed By: _____ Date: _____

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www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Manager Code _____
Client No. _____

My name is _____

I live at _____

Warning: Title 18, Section 1001 of the United States code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Making false statements is a felony under California State Law (penal code sections: 115, 118, 487, 532) and may result in criminal charges including perjury, grand theft, filing false documents with a public office, and obtaining money under false pretenses.
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Knowing the penalty for making a false statement under the United States Code, I hereby certify that the following is a true, correct, and complete statement.

_____

_____

_____

_____

_____

_____

_____

_____

_____

This statement was completed, signed and dated knowingly, freely, and voluntarily, without threats or duress from anyone to obtain my statement.

Signature _____ Date _____

Witnessed By: _____ Date: _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
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DECLARACION CERTIFICADA

Nombre: _____

Domicilio:_____

ADVERTENCIA: El Título 18, Sección 1001 del Código de los Estados Unidos establece que una persona es culpable de un delito grave si a sabiendas y por voluntad propia hace declaraciones falsas o fraudulentas a un departamento u oficina de los Estados Unidos. Hacer declaraciones falsas es un delito grave bajo la ley del Estado de California (Código Penal Secciones: 115, 118, 487 y 532) y puede traer como consecuencia cargos penales, como perjurio, hurto mayor, entregar documentos falsos a una oficina pública y obtener dinero de manera fraudulenta.
La sección 35 (A) del Código penal de los Estados Unidos considera una ofensa criminal, con pena máxima de encarcelamiento por 10 años, multa de $10,000 dólares o ambos, el hacer una declaración falsa o representación a cualquier Departamento de los Estados Unidos en cualquier asunto dentro de su jurisdicción. La información proporcionada arriba fue solicitada por la AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ÁNGELES en su capacidad como una Ciudad, Estado, y Agencia Federal.

Conociendo la pena bajo el Código de Los Estados Unidos por hacer declaraciones falsas, por el presente doy fe que la siguiente es una declaración verdadera, cierta y completa:

_____

_____

_____

_____

_____

_____

_____

Esta declaración fue terminada, firmada y fechada con conocimiento, libremente, y voluntariamente, sin amenazas o la compulsión de cualquier persona para obtener mi declaración.

Firma _____ Fecha _____

Testimonio de _____ Fecha _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

LIMITED ENGLISH PROFICIENCY NOTICE – SECTION 8

The Housing Authority of the City of Los Angeles is sensitive to the needs of individuals with Limited English Proficiency (LEP) and is committed to ensure equal access to its services.

If you are an individual with limited English skills and would like to communicate either orally or in writing in a language other than English, please indicate your language preference on the form on the back of this notice and submit it to your HACLA worker.

NOTIFICACIÓN DE CAPACIDAD LIMITADA EN INGLÉS - ***Spanish***

La Autoridad de Vivienda de la Ciudad de Los Ángeles es sensible a las necesidades de las personas con Capacidad Limitada en Inglés (LEP, por sus siglas en inglés) y está comprometida a asegurar el acceso igualitario a sus servicios.

Si es una persona con habilidades limitadas en inglés y quisiera comunicarse verbalmente o por escrito en un idioma que no sea inglés, por favor, indique la preferencia de su idioma en el formulario en la parte trasera de esta notificación y preséntela a su empleado de la HACLA.

ՍԱՀՄԱՆԱՓԱԿ ԱՆԳԼԵՐԵՆԻ ԻՄԱՑՈՒԹՅԱՆ ԾԱՆՈՒՑԱԳԻՐ - ***Armenian***

Լոս Անջելես Քաղաքի Բնակարանվորման Իշխանությունը ըմբռնումով է մոտենում Սահմանափակ Անգլերենի Իմացության (LEP) տեր անձանց խնդիրներին և հանձն է առել երաշխավորել իր ծառայությունների հավասար մատչելիությունը:

Եթե դուք ունեք սահմանափակ անգլերենի ունակություններ և ցանկանում եք բանավոր կամ գրավոր հաղորդակցվել ոչ-անգլերեն լեզվով, խնդրում ենք այս ծանուցագրի հետևի էջին գտնվող ձևաթղթի վրա նշել ձեր լեզվական նախասիրությունը և ներկայացնել HACLA-ի ձեր ներկայացուցչին:

СООБЩЕНИЕ ДЛЯ ЛИЦ С ОГРАНИЧЕННЫМ УРОВНЕМ ВЛАДЕНИЯ АНГЛИЙСКИМ ЯЗЫКОМ – ***Russian***

Жилищное Управление Лос-Анджелеса (ЖУЛА) внимательно относится к нуждам лиц с ограниченным уровнем владения английским языком (ОУВА) и прилагает все усилия для обеспечения равной возможности получения информации о его услугах.

Если вы являетесь лицом с ограниченным уровнем владения английским языком и желаете общаться, устно или письменно, на другом (то есть не на английском) языке, просим сообщить о вашем предпочтении в отношении используемого языка вашему работнику ЖУЛА.

제한적 영어 사용자 통지문 – ***Korean***

로스앤젤레스 주택국(The Housing Authority of the City of Los Angeles)은 제한적 영어 사용자 (LEP)의 필요점을 잘 알고 있으며 주택국이 제공하는 서비스를 동일하게 이용할 수 있도록 최선의 노력을 다하고 있습니다.

제한적 영어 구사자로써 영어이외의 언어로 구두나 문서로 통신하고 싶으시면 HACLA 직원에게 원하는 언어를 말씀해 주십시오.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

LIMITED ENGLISH PROFICIENCY NOTICE – SECTION 8

☐ I prefer **Oral** Communication in English	☐ I prefer **Written** Communication in English	**English**
☐ Prefiero comunicación **oral** en español	☐ Prefiero comunicación **escrita** en español	**Spanish**
☐ Ես նախընտրում եմ **Բանավոր** հաղորդակցությունը հայերենով	☐ Ես նախընտրում եմ **Գրավոր** հաղորդակցությունը հայերենով	**Armenian**
☐ Я предпочитаю **Устное** общение на русском языке	☐ Я предпочитаю **Письменное** общение на русском языке	**Russian**
☐한국어로 구두 통신을 하고 싶습니다	☐한국어로 문서 통신을 하고 싶습니다	**Korean**
☐Other _____	☐Other _____	

_____ _____ _____

Name Signature Date

HACLA USE ONLY

Cal/Mgr Code: _____ Client No.: _____

PLACE HERE

INCOME VERIFICATION including the following:

- Verification of Employment and Earnings (3 months of pay stubs) (if applicable)
- Verification of DPSS Assistance (Notice of Action)
- Verification of Social Security Benefits
- Unemployment / State Disability Insurance Award Letter & 3 consecutive check stubs
- Child Support Payment History Chart & 3 consecutive check stubs
- Adoption / Foster Care / Kin-Gap Assistance Payment Letter
- Self-Employment – all pages of most recent year Tax Returns, W'2s & 1099s
- Bank Verification of Income and Assets (1 month bank statement) *for* ***every*** *household bank account*
- Verification of Contributions Received
- Retirement Income Verification Letter
- Life Insurance
- Pension / Annuity Award Letter

PLACE HERE

Copy of each household member's California Identification Card (ID) or Driver's License. **If the CA ID/DL expires before the client is housed, the application will be withdrawn;** therefore, if the ID/DL is within 6 months of expiration, ask the client to renew their ID at the DMV. Submit a copy of the DMV application/receipt with the HACLA application.

-and-

Copy of each household member's **signed** Social Security Card. If it is not signed, the application will be returned to the clinic/agency that submitted it.